TRANSCRIPT OF RECORD

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1957

No. 436

FEDERAL TRADE COMMISSION, PETITIONER,

vs.

THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR CERTIORARI FILED SEPTEMBER 6, 1957

CERTIORARI GRANTED NOVEMBER 12, 1957

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[fol. 1]

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 16,132.

THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY,

versus

FEDERAL TRADE COMMISSION.

PETITIONER'S DESIGNATION AS TO PRINTING RECORD—Filed September 9, 1956

1. Complaint.

2. Plea to the jurisdiction and answer of The American Hospital and Life Insurance Company, which was transmitted to the commission for filing on November 8, 1954, and which must have been filed shortly thereafter.

3. Motion to dismiss No. 2 filed by The American Hospital and Life Insurance Company with Hearing Examiner July 9, 1955.

4. Motion to dismiss No. 3 filed by The American Hospital and Life Insurance Company with Hearing Examiner July 9, 1955.

5. Initial Decision by J. Earl Cox, Hearing Examiner, filed December 8, 1955.

[fol. 2] 6. Findings as to Facts, Conclusions and Order by the Commission, issued April 24, 1956.

7. Opinion of the Commission dated April 24, 1956.

8. Joint dissenting opinion of Chairman Gwynne and Commissioner Mason, dated April 24, 1956.

9. Additional views of Commissioner Mason dated April 24, 1956.

The American Hospital and Life Insurance Company,
By J. D. Wheeler, General Counsel.

[fol. 3] IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

PETITION FOR REVIEW OF ORDER OF THE FEDERAL TRADE COMMISSION—Filed May 30, 1936

To the Honourable Judges of the United States Court of Appeals for the Fifth Circuit:

Your Petitioner, The American Hospital and Life Insurance Company, a corporation organized, existing and doing business under and by virtue of the laws of the State of Texas, with its principal place of business located at San Antonio, Texas, respectfully presents its petition for a review of the Order of the Federal Trade Commission bearing date of April 24, 1956, Docket No. 6237, wherein Petitioner was ordered to cease and desist from certain practices allegedly in violation of the Federal Trade [fol. 4] Commission Act of 1914 as amended. (Title 15, U.S.C.A., Sec. 42, et seq.) This petition is filed in this Court pursuant to Section 5(c), Title 15, U.S.C.A., Section 45(c).

The Order above referred to is attached to and made a part of the so-called Findings as to the Facts and Conclusions to the effect that the Federal Trade Commission has jurisdiction over all of Petitioner's acts and practices alleged in the Complaint to be unlawful, and that the acts and practices of Petitioner are to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act.

Petitioner respectfully represents:

1. That the Federal Trade Commission had no jurisdiction to file the Complaint here involved or to enter the Order complained of and that all of the acts and actions of the Federal Trade Commission in this regard and all of the orders entered by it, including the final order against which this petition for review is directed, are wholly outside of the jurisdiction of the Federal Trade Commission and that the Federal Trade Commission has no jurisdiction of the subject matter hereof because by the Act of Congress of March 9, 1945, Chapter 20, Sections 1 to 5, both inclusive, 59 Stat. 33 and 34 as amended by Act of July

25, 1947, Chapter 326, 61 Stat. 448, now carried in the United States Code Annotated, Title 15, Sections 1011 to 1015, both inclusive, known as the McCarran Act, Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest and that silence on the part of Congress shall not [fol. 5] be consfrued to impose any barrier to the regulation or taxation of such business by the several states; and provided further that the business of insurance and every person engaged therein shall be subject to the laws of the several States which relate to the regulation or taxation of such business; and provided further that no act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance or which imposes a fee or tax upon such business unless such Act specifically relates to the business of insurance with the proviso that after June 30, 1948, the Act of September 26, 1914, known as the Federal Trade Commission Act as amended shall be applicable to the business of insurance to the extent that such business is not regulated by State law. That in all of the States in which Petitioner transacts the business of insurance such insurance business is adequately and effectively regulated by State law.

2. Finding of Fact No. 7, as set out on page 4 of the Findings as to the Facts, Conclusions and Order, is not supported or based upon any substantial or credible evidence and is contrary to the undisputed evidence in this record.

3. Finding of Fact No. 8, as set out on pages 4 and 5 of the Findings as to the Facts, Conclusions and Order, is not supported or based upon any substantial or credible evidence and is contrary to the undisputed evidence in this record.

4. Finding of Fact No. 9, as set out on pages 5 and 6 of the Findings as to the Facts, Conclusions and Order, [fol. 6] is not supported or based upon any substantial or credible evidence and is contrary to the undisputed evidence in this record.

5. That the Federal Trade Commission's Conclusion No. 1, set out on page 6 of the Findings as to the Facts, Conclusions and Order, has no foundation in fact or law, the

Federal Trade Commission having no jurisdiction of the subject matter of the Complaint.

6. That Petitioner not having disseminated any false or deceptive matter no public interest is involved in this proceeding as asserted in Conclusion No. 2 set out on page 6 of the Findings as to the Facts, Conclusions and Order.

7. That Conclusion No. 3, set out on page 6 of the Findings as to the Facts, Conclusions and Order, has no foundation either in fact or in law and is wholly unwarranted under the record in this case.

8. That Conclusion No. 4, set out on page 6 of the Findings as to the Facts, Conclusions and Order, has no foundation either in fact or in law and is wholly unwarranted under the record in this case.

9. That Petitioner will set out in its brief to be filed in the United States Court of Appeals for the Fifth Circuit as provided by the Rules, all of the points upon which it relies.

Wherefore, your Petitioner prays that the aforesaid Order of the Federal Trade Commission be reviewed by this Honorable Court and that upon such review the said cease and desist order of the Federal Trade Commission [fol. 7] entered in their Docket No. 6237 against Petitioner be set aside and held for naught. Petitioner prays for such other and further relief as to the Court may seem meet and just.

The American Hospital and Life Insurance Company,
By S. E. McClellan, President, J. D. Wheeler,
Counsel for Petitioner.

Of Counsel: Boyle, Wheeler, Gresham, David & Gregory, 1603 Alamo National Building, San Antonio 5, Texas.

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

ORDER TO FILE PETITION—May 30, 1956

A petition for review of an Order of the Federal Trade Commission of April 24, 1956, Docket No. 6237, having been presented to this Court;

[fol. 8] It Is Ordered that said petition be filed and docketed as of May 30, 1956;

And it is further ordered that a copy of this order and said Petition be forthwith served upon the Federal Trade Commission, and that said Federal Trade Commission, upon service of such copies, forthwith certify and file in this Court, a transcript of the entire record in the proceedings, in conformity to Rule 38 of this Court.

(S.) John A. Feehan, Jr., Clerk of the United States Court of Appeals for the Fifth Circuit.

New Orleans, Louisiana, May 30, 1956.

BEFORE FEDERAL TRADE COMMISSION

In the Matter of THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY, a Corporation

Docket No. 6237.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as that Act is applicable to the business of [fol. 9] insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015, inclusive), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that The American Hospital and Life Insurance Company, a corporation, hereinafter referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, stating its charges in that respect as follows:

Paragraph One: Respondent, The American Hospital and Life Insurance Company, is a corporation, duly organized, existing and doing business under and by virtue of the laws of the State of Texas with its office and principal place of business located at Pecan & St. Mary's Streets in the City of San Antonio, Texas.

Paragraph Two. Respondent is now, and for more than two years last past has been, engaged as an insurer in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by entering into insurance contracts with insureds located in various States of the United States other than the State of Texas, in which states the business of insurance is not regulated by state law to the extent of regulating the practices of respondent alleged in this complaint to be illegal. Respondent maintains, and at all times mentioned herein has maintained, a substantial course of trade in said insurance policies in commerce between and among the several States of the United States.

[fol. 10] Respondent during the two years last past has sold insurance indemnification provided in a variety of policies, among which are the following:

(1) American Family Accident Policy, identified by respondent as form A(1)-7-53.
(2) American Standard Accident Policy, identified by respondent as form ASA(1-50).
(3) All American Accident Policy, identified by respondent as AAA(1-50).
(4) Income Protection Policy, identified by respondent as form A&H3-1949.
(5) Business and Professional Men and Women's Income Policy, identified by respondent as form BPI.
(6) Preferred Individual Hospital and Surgical Insurance Policy, identified by respondent as form PRI-12.
(7) American Economy Hospital and Surgical Insurance Policy, identified by respondent as form AE Rev.
(8) All American Automobile Accident Policy, identified by respondent as form AAAA.

Paragraph Three: Respondent is licensed, as provided by the respective state laws to engage in the business of insurance as heretofore generally described in the States of Arizona, Arkansas, Colorado, Illinois, Indiana, Kentucky, [fol. 11] Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee and Texas. Respondent is not now, and for more than two years last past has not been, licensed as provided by the respective state laws to engage

in the business of insurance in any state of the United States other than those above mentioned.

Respondent has sold a substantial number of its said policies to insureds now residing in states other than those in which respondent has been duly licensed, as aforesaid, and respondent mails to such insureds or policyholders notices and receipts relating to the payment of renewal premiums and receives and accepts from such insureds or policyholders premiums mailed to it renewing the coverage purchased for the period of time covered by the premium submitted. The renewal of term insurance in this manner constitutes trade in commerce to the same extent as the original purchase of said insurance.

Paragraph Four: In the course and conduct of its aforesaid business, respondent, during the two years last past, disseminated and caused to be disseminated in the form of circulars and other printed and written matter, false, misleading and deceptive advertisements concerning the terms and provisions of various of its policies of insurance. These advertisements were disseminated by the United States mails, or through the licensed agents of respondent, in commerce between and among the various states of the United States. The purpose and effect of these advertisements was, and is, to induce members of the public to become insured by the respondent under the terms and provisions of the policies advertised.

[fol. 12] Paragraph Five: In the course and conduct of its said business in commerce, as aforesaid, the respondent has disseminated, among others of similar import and meaning, not herein set out, advertisements relating to its said policies containing statements hereinafter set forth, as follows:

1. "No Age Provision terminating or reducing benefits because of increasing age."

"Issued to Men, Women, and Children, Ages 3-60."

"Issued to Men and Women, ages 18 to 60."

2. Confining Illness Indemnity for loss of time from illness, beginning on the fourth day and continuing for one year for each illness. . ."

3. "It Will Pay. . . Medical Costs for Accidents"

Pays You A Monthly Income when you are disabled because of accident • • • "

"Covers Accidents"

"Pays from First Day of disability for each accident . . . "

"Monthly Indemnity for Loss of Time by Accidents"

4. "Surgery From $3.00 to $150.00 Depending on seriousness of operation."

5. "Room Service
Hospital Expense
Surgery
Additional Benefits
Maternity . . ."

Paragraph Six: Through the use of said statements and representations, and others of similar import and [fol. 13] meaning, not specifically set out herein, respondent represents and has represented, directly or by implication, with respect to said policies:

1. That the indemnification provided by respondent's policies may be continued to age 60 or for an indefinite period at the option of the insured.

2. That respondent's policies provide indemnification for any or all sickness or illness.

3. That respondent's policies provide indemnification for all or any accidents.

4. That policy AE Rev. 9-52, the policy referred to by the representation set out in subparagraph 4 of Paragraph Five, provides for the payment of $150.00 for any operation serious enough to justify such a surgeon's fee.

5. That policy AE Rev. 9-52, the policy referred to, provides for the payment of maternity benefits in addition to payments for room service and hospital expense.

Paragraph Seven: The aforesaid statements and representations are false, misleading and deceptive. In truth and in fact:

1. Respondent's policies are term policies and are renewable at the option of the respondent only. Further, the policy is automatically terminated upon the payment of certain cash benefits.

2. Respondent's policies do not provide indemnification [fol. 14] for each, any, or all sickness; on the contrary, the policies which provide indemnification in the form of

a monthly confining sickness benefit limit such indemnification for sickness which shall wholly, necessarily and continuously disable and prevent the insured from engaging in any business, profession, or employment and be disabled and strictly and continuously confined in the house, and be therein visited and regularly attended by a legally qualified physician (M.D.) or surgeon (M.D.) or osteopath other than himself. In cases of illness which is non-confining, but otherwise limited as above, indemnification will be limited to two months. No indemnification in the form of a monthly non-confining sickness benefit will be paid for the first three days of disability after the first treatment by a legally qualified doctor, surgeon, or osteopath, and no indemnification will be paid except for the period after and during continuous medical treatment.

Policy A&H3, concerning which the representation set out in subparagraph 2 of Paragraph Five was made, provides that no payment shall be made in cases of sickness commencing prior to the effective date of said policy. And if the insured is a female, no indemnity will be provided for loss from pregnancy, childbirth or miscarriage. Nor is indemnity provided for any sickness occurring outside the 48 States, the District of Columbia, or Canada south of the 60 degree north latitude.

3. Respondent's policies BPI (1-52), A&H3-1949, and AAA (1-50), the policies concerning which the representation set out in subparagraph 3 of Paragraph Five were made, do not provide indemnification for all cases of acci- [fol. 15] dental injury. On the contrary, indemnification is provided only when such injury shall, commencing within 20 days after the date of the accident, at least, continuously disable and prevent the insured from performing one or more important daily duties pertaining to his occupation and while under regular medical care.

4. In fact, policy AE Rev. 9-52 provides for the payment of $150 for surgeons' fees for only six out of sixty-seven different listed operations. For twenty-nine of the listed operations, $25 or less is allowed.

5. Policy AE Rev. 9-52 does not provide for the payment of maternity benefits in addition to payments for room service and other hospital expense. Maternity benefits are paid in lieu of all other benefits provided by said policy for hospital services.

Paragraph Eight: The use by the respondent of the aforesaid false and misleading statements and representations with respect to the terms and conditions of its said policies and its failure to reveal the limitations of said coverage found in said policies have had and now have the tendency and capacity to mislead and deceive and have misled and deceived a substantial portion of the purchasing public into the erroneous and mistaken belief that the aforesaid statements and representations were and are true and to induce said portion of the purchasing public to purchase insurance coverage from the respondent because of said erroneous and mistaken belief.

Paragraph Nine: The aforesaid acts and practices of respondent, as herein alleged, are all to the prejudice and injury of the public and constitute unfair and deceptive [fol. 16] acts and practices in commerce within the intent and meaning of the Federal Trade Commission Act.

Wherefore, The Premises Considered, the Federal Trade Commission on this 14th day of October, 1954, issues its complaint against said respondent.

Notice

Notice is hereby given you, The American Hospital and Life Insurance Company, a corporation, respondent herein, that the 20th day of December, A. D. 1954, at 10 o'clock is hereby fixed as the time and San Antonio, Texas as the place when and where a hearing will be had before J. Earl Cox, a hearing examiner of the Federal Trade Commission, on the charges set forth in this complaint, at which time and place you will have the right under said Act to appear and show cause why an order should not be entered requiring you to cease and desist from the violations of law charged in this complaint.

You are notified that the opportunity is afforded you to file with the Commission an answer to this complaint on or before the twentieth (20th) day after service of it upon you. Such answer shall contain a concise statement of the facts which constitute the ground for defense and shall specifically admit or deny each of the facts alleged in the complaint, unless you are without knowledge, in which case you shall so state. Failure to file an answer

to or plead specifically to any allegation of the complaint shall constitute an admission of such allegation.

[fol. 17] If respondent desires to waive hearing on the allegations of fact set forth in the complaint and not to contest the facts, the answer may consist of a statement that respondent admits all the material allegations of fact charged in the complaint to be true. Such answer will constitute a waiver of any hearing as to the facts alleged in the complaint and findings as to the facts and conclusions based upon such answer shall be made and order entered disposing of the matter without any intervening procedure. The respondent may, however, reserve in such answer the right to submit proposed findings and conclusions of fact or of law under Rule XXI, and the right to appeal under Rule XXIII.

Failure to file answer within the time above provided and failure to appear at the time and place fixed for hearing shall be deemed to authorize the Commission and Hearing Examiner J. Earl Cox, without further notice, to find the facts to be as alleged herein and to issue the following order in this proceeding:

It Is Ordered that respondent, The American Hospital and Life Insurance Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from:

[fol. 18] (A) Representing, directly or by implication:

(1) That said insurance policy may be continued in effect indefinitely or for any period of time, when, in fact, said policy provides that it may be canceled by respondent or terminated under any circumstances over which insured has no control, during the period of time represented.

(2) That said policy provides for indemnification to insured in cases of sickness or accident generally or in any or all cases of sickness or accident, when such is not the fact.

(3 That said policy will pay in full or in any specified amount or will pay up to any specified amount for any

medical, surgical or hospital service unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented.

(4) That said policy provides for the payment of certain benefits in addition to other benefits when such is not the fact.

(B) Misrepresenting in any other manner or by any other means the terms or provisions of said insurance policy.

The inclusion of such order to cease and desist in this complaint will be without effect in the event you show cause, on or before the 20th day of December, A. D. 1954, why such order should not issue.

In Witness Whereof, the Federal Trade Commission has [fol. 19] caused this, its complaint, to be signed by its Secretary, and its official seal to be hereto affixed, at Washington, D. C. this 14th day of October, 1954.

By the Commission.

Robert M. Parrish, Secretary.

BEFORE FEDERAL TRADE COMMISSION

PLEA TO JURISDICTION AND ANSWER—Received Nov. 9, 1954

To Said Honorable Commission:

Now comes The American Hospital and Life Insurance Company, named as Respondent in the complaint filed in the above styled and numbered cause, and appearing solely for the purpose of filing this plea contending that the Federal Trade Commission has no jurisdiction against The American Hospital and Life Insurance Company, and respectfully represents:

1. That by Act of Congress of March 9, 1945, Chapter 20, Sections 1 to 5, both inclusive, 59 Stat. 33 and 34, as [fol. 20] amended by Act of July 25, 1947, Chapter 326, 61 Stat. 448, now carried in the United States Code Annotated, Title 15, Sections 1011 to 1015, both inclusive, Congress declares that the continued regulation and taxation by the several states of the business of insurance is

in the public interest and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several states, and provided further that the business of insurance and every person engaged therein shall be subject to the laws of the several states which relate to the regulation or taxation of such business; and provided further that no Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any state for the purpose of regulating the business of insurance or which imposes a fee or tax upon such business unless such act specifically relates to the business of insurance with the proviso that after June 30, 1948, the Act of September 26, 1914, known as the Federal Trade Commission Act as amended shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

2. That Respondent does not transact any mail order business of insurance but deals through branch offices, agents and salesmen residing in the various states in which it has permits to do business, and that its business is transacted through individual and personal contacts between the managers, agents, salesmen and employees located in said states on the one hand and prospects for insurance and policy holders on the other hand.

3. That the subject of advertising and as to what constitutes improper advertising and as to what constitutes [fol. 21] false, deceptive and misleading statements and representations has been and is now being regulated by the laws of the various states in which Respondent has a permit to do business and in which it does do business, it being so regulated by said states law and by the Insurance Departments of the various states operating under said laws. That this Honorable Commission has no jurisdiction of the subject matter of the complaint which has been filed, such jurisdiction being denied by the Congress of the United States and therefore this cause should be by the Honorable Federal Trade Commission dismissed.

Wherefore, Respondent prays that this cause be dismissed for want of jurisdiction.

ANSWER

Without waiving the above and foregoing plea of jurisdiction, but still insisting on same and specifically subject

to the action of your Honorable Commission thereon, Respondent respectfully represents to the Commission:

A. Respondent denies that this complaint has been filed pursuant to the Act of Congress referred to in the first paragraph of the complaint, but respectfully represents that this complaint has been filed contrary to the provisions of said Act. Respondent denies the allegations of paragraph One of the complaint.

B. Respondent admits the allegations of Paragraph Two of the complaint only insofar as such allegations do not conflict with the facts set out in Respondent's plea to the jurisdiction hereinabove set out, and insofar as the allegation of said Paragraph Two conflict with Respondent's allegations set out in the plea to the jurisdiction they are hereby denied.

[fol. 22] C. Respondent admits that it has sold and is selling the policies listed (1) to (8) in said Paragraph Two.

D. Respondent admits that it is licensed in the states listed in Paragraph Three of the complaint, but Respondent denies the allegation contained in said Paragraph Three to the effect that it has sold a substantial number of its policies to insureds now residing in states other than those in which Respondent has been duly licensed, except there have been a few instances in which persons have purchased insurance policies in states in which Respondent is licensed to sell insurance, which persons have moved to states in which Respondent is not licensed to sell insurance, and such policy contracts being in effect Respondent does mail to such policyholders notices and receipts relating to the payment of renewal premiums and receives and accepts from such policyholders premiums mailed to it. That such contracts having been legally entered into in states in which Respondent is duly authorized to transact its insurance business it is equally obligated to carry out the terms of said contracts when such policyholders move to other states.

E. Respondent denies the allegations of Paragraph Four of the complaint alleging that Respondent has disdisseminated and caused to be disseminated in the form of circulars and other printed and written matter false, misleading and deceptive advertisements concerning the terms and provisions of the various policies of insurance

issued by it, and in this connection Respondent says that it is — no sense a mail order insurance company, that it does not send through the United States mails advertis- [fol. 23] ing matter to prospects for insurance, but that its advertising matter is transmitted to its branch offices in the various states and is used by the managers, salesmen and agents in connection with the presentation personally by said representatives of Respondent to prospects of insurance in connection with the application to be executed by such applicant if he or she makes application for insurance coverage. That such advertising matter is in the form of four leaf pamphlets on two of which is contained fair and true representations, on the third page of which is set out the application to be signed, and the fourth page of which is generally blank, but if it is not blank there merely appears thereon a schedule of rates, charged by Respondent for the various types of insurance policies offered. That said advertising matter contains the statement in large type either that the insurance offered is subject to the policy terms or that it is limited by the policy terms, or some similar statement, putting the applicant upon fair notice that the policy which is to be written contains provisions and limitations.

Furthermore, in connection with procuring the application of the prospect the agents and salesmen explain fully to the prospect the terms of the policies to be issued and the provisions and limitations as to the coverage of such policies. Respondent further alleges that all applicants for insurance are aware of the fact that there is no such thing in the trade and industry as a blanket policy which covers every condition of illness and every accident, but that every policy of insurance contains limitations of coverage, and Respondent says that all of its policies contain provisions which are fair and reasonable limitations of coverage and [fol. 24] this fact is well known to all of its applicants for insurance.

F. Respondent admits that the words set out in 1, 2, 3, 4 and 5 of Paragraph Five are contained in Respondent's advertising, but Respondent says that as set out in the complaint in many instances the words quoted in the complaint are only part of the statement made in the advertising, and the charge as made is wholly unfair because

quoting the rest of the sentence in which many of said words appear they are expressly limited and the meaning of the representation is in no sense the same as the complaint would imply.

Taking these up one by one:

"No age provision terminating or reducing benefits because of increasing age."

"Issued to men, women and children, ages 3-60."

"Issued to men and women, ages 18 to 60."

1. The provision first quoted appears in the advertising matter and the policy issued pursuant thereto does not contain any age provision terminating or reducing benefits because of increased age. Therefore, Respondent says that said representation is a fair and true representation of the terms of the policy issued pursuant thereto.

2. In reference to the provision "Issued to men, women and children, 3-60", Respondent says that said words do appear but the whole representation is not alleged. The whole representation appearing in bold face type is as follows: "Policy A(1) issued to men, women and children [fol. 25] 3-60. Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health."

Respondent says that said representation is entirely in accord with the policy issued, and Respondent further says that it is patently unfair for the complaint to be based on only a portion of said representation.

3. In reference to the provision "Issued to men and women, ages 18 to 60", Respondent says that said words do occur but the whole representation is not alleged. The whole representation appearing in bold face type is as follows: "Policy form ASA issued to men and women, ages 18 to 60. Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health."

Respondent says that said representation is entirely in accord with the policy issued, and Respondent further says that it is patently unfair for the complaint to be based on only a portion of said representation.

4. In reference to the provision "Confining illness indemnity for loss of time from illness, beginning on the fourth day and continuing for one year for each illness",

Respondent says that the words do occur but the complaint unfairly takes such representation entirely out of context and that the criticism thereof contained in the second paragraph of Paragraph Five is wholly unfair and unwarranted for the following reasons:

(a) On the same page on which said words occur there appears in bold face type in describing the policy to be [fol. 26] issued, "Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health." And, further, at the bottom of the page on which said words appear, also in bold type, there appears the following, "Benefits described above are contingent on recommendation of applicant by authorized company representative and *are subject to the terms of the policy issued.*" (Emphasis ours) Also, on said page as a part of the receipt which is furnished applicant there appears "If for any reason the application is not approved and policy issued this payment is to be refunded."

Furthermore, said statement appears on the left hand inside page of the folder and right hand inside page of the same folder is the application for the policy to be signed by the applicant. This application contains in bold type various questions to be answered by the applicant, the negative answers thereto constituting a representation that the applicant is and has been in good health. Furthermore, questions 16 and 17 to be answered affirmatively as a condition precedent to the issuance of the policy are a representation on the part of applicant not only that he or she must be in good health on the date of the issuance of the contract but also that such policy will not become effective unless the applicant is in good health on such issuing date, and furthermore, there is set out whatever limits the policy contains as to when the benefits are payable in relation to the inception of the illness.

Therefore, Respondent alleges that the charge of the complaint to the effect that misrepresentation has been made because the policy provides that no payment shall [fol. 27] be made in cases of illness commencing prior to the effective date of the policy is wholly unfair and without foundation because the application which the applicant signs contemplates not only that there shall be no sickness commencing prior to the effective date of the policy but

that if there is such illness that the policy never becomes effective at all. That the limitations contained in the policy as to non-coverage of pregnancy, child birth or miscarriage, and as to residents outside of the United States and in Canada north of 60° north latitude are entirely reasonable limitations because no representation is made in the advertising that all confining illnesses are covered and the applicant is placed upon notice of reasonable limitations by the statement made in bold type that all of the benefits described are subject to the terms of the policy issued.

Again Respondent calls attention to the fact that there is no such thing as an all inclusive illness policy but that all of such policies contain at least reasonable limitations of liability and all prospective purchasers of policies are well aware of the fact that policies do contain limitations of liability, and when the advertising matter states positively that the benefits offered are subject to the terms of the policy it is incumbent upon the applicant to inquire as to what limitations are contained in the policy, and Respondent alleges further that in selling all policies of insurance the agents and salesmen are directed to call the applicant's attention to the limitations contained in the policies and that such limitations are actually called to the attention of the applicant when the insurance is sold.

[fol. 28] . 5. In reference to the provision "It will pay medical costs for accidents", Respondent says that such statement is limited up to $500.00, and on the same page there is the provision in bold type to the effect that the benefits described above are subject to the terms of the policy issued. Respondent denies that such representation is in any way untrue or unfair, but Respondent says that the policy issued provides the benefits as represented.

6. In reference to the provision "Pays you a monthly income if you are disabled because of accident" Respondent says that said words do appear but the whole representation is not alleged. The whole representation appearing is as follows: "Pays you a monthly income when you are disabled because of accident, according to the terms of the policy." Furthermore, on the same page of the folder describing the policy to be issued there is the statement in bold type "Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health."

Respondent says that said representation is entirely in accord with the policy issued, and Respondent further says that it is patently unfair for the complaint to be based on only a portion of said representation. Respondent further says that when the representation in the same sentence and in the same bold type states that the coverage is according to the terms of the policy the applicant is put upon inquiry as to what limitations the policy contains, and Respondent says that the provision that the coverage is as to accident which in case of total disability wholly disables the injured person within 20 days after the accident, [fol. 29] and as to partial disability, partially disabling the insured within 20 days after the date of accident is a reasonable provision reasonably protecting the company against fraud and pretended and simulated accident, and is a limitation concerning which the applicant was put upon inquiry before he applied for the insurance.

7. In reference to the provision, "Covers accidents", Respondent says that said words do appear but the whole representation is not alleged. The whole representation appearing is as follows: "Covers accident, subject to the policy terms."

On the same page on which said words occur there appears in bold face type in describing the policy to be issued, "Only persons engaged in non-hazardous occupations are eligible, and all applicants must be in good health." Respondent says that said representation is entirely in accord with the policy issued, and Respondent further says that it is patently unfair for the complaint to be based on only a portion of said representation. Instead of the advertising matter being a representation that the policy to be issued will provide indemnification for all cases of accidental injury the advertising matter not only expressly limits the benefits to non-hazardous occupations but also to such limitations as the policy may contain, and there is no representation in the advertising matter anywhere that the policy will cover all accidents.

8. In reference to the provision "Pays from first day of disability for each accident", Respondent says that the policy issued does pay from the first day of disability for each accident covered by the policy; that the advertising [fol. 30] provides plainly that it covers accidents subject

to the policy terms; that only persons engaged in non-hazardous occupations are eligible and the applicant is fairly put upon inquiry as to the limitations contained in the policy and these limitations are explained to the applicant by the salesman in connection with taking the application for the policy.

9. In reference to the provision "Monthly indemnity for loss of time by accident", Respondent says that for the same reasons as hereinabove alleged as to the other provisions said representation is a fair representation of the policy to be issued and constitutes no false representation, either express or implied.

10. In reference to the provision quoted in Subsection 4 of Paragraph Five Respondent says that the detailed schedules of surgical operations set out in Respondent's policy is entirely in accord with the representation quoted.

11. In Paragraph Six, Sub-section 4, it is charged that the provision above referred to either directly or by implication represents that the policy provides for the payment of $150.00 for any operation serious enough to justify such a surgeon's fee. Respondent says that the representation referred to is in no way fairly subject to the implication charged. The representation from $3.00 to $150.00 depending on the seriousness of the operation carries with it no implication except payments will be made on a graduated scale dependent upon whether the operation is a trivial operation or a serious one and the only impression [fol. 31] that could fairly be acquired by the prospect is that a graduated schedule will be contained in the policy offered for sale. In the schedule referred to the benefits allowed are in accord with the relative difficulty and seriousness of the various operations. There is no representation in the advertising matter that the policy will pay the entire charge made by the surgeon, and Respondent says that the construction attempted to be placed on said representation in the complaint is unjustified by the language of the representation.

12. In Sub-section 4 of Paragraph Seven it is alleged that said representation is false, misleading and deceptive because the policy provides for the payment of $150.00 for surgeon's fee for only six out of sixty-seven different listed operations, and that for twenty-nine of the listed opera-

tions $25.00 or less is allowed. That as a matter of fact said schedule is as follows: Four operations at $5.00, five at $10.00, three at $15.00, five at $20.00, twelve at $25.00, three at $30.00, four at $40.00, nine at $50.00, six at $75.00, seven at $125.00, and six at $150.00.

Respondent represents that such graduation of fees is a fair and reasonable schedule of fees in response to the representation that Respondent pays from $3.00 to $150.00, depending on the seriousness of the operation, except that there are no operations in said schedule for which Respondent pays less than $5.00.

In reference to the allegations in the complaint relating to maternity benefits and the charge that placing maternity benefits under a heading "Additional Benefits" is misleading when the maternity benefits paid are in lieu of all [fol. 32] other benefits in the policy, Respondent says that it is well known that in many policies maternity benefits are excluded and therefore there is no misrepresentation in listing maternity benefits under the heading "Additional Benefits". It will be noted that in the advertising matter maternity benefits are limited to a lump sum stated in the advertising matter and this is a representation to the effect that said maximum is the greatest amount which will be paid in reference to maternity cases. However, if it is considered that said representation is not entirely clear, Respondent will be glad to place in its advertising matter the direct statement that the lump sum amount for maternity benefits is in lieu of all other hospital benefits in maternity cases.

For the reasons set out in detail above Respondent denies the allegations in Paragraph Six, Sub-sections 1, 2, 3, 4 and 5 of the complaint.

13. In reference to Sub-section 1 of Paragraph Seven of the complaint Respondent says that none of Respondent's advertising matter is inconsistent with the fact that Respondent's policies are term policies nor is there any representation in any of the advertising matter, either expressly or by implication, that Respondent's policies are non-cancellable policies.

14. In reference to Sub-section 2 of paragraph Seven of the complaint Respondent says that nowhere in Respondent's advertising matter is there a representation,

either expressly or impliedly, that Respondent's policies provide indemnification for ~~each~~, any or all sickness.

[fol. 33] 15. In reference to Sub-section 3 of Paragraph Seven of the complaint Respondent says that in none of its advertising is there any representation expressly or impliedly that it will provide indemnification for all cases of accidental injury.

16. Sub sections 4 and 5 of Paragraph seven have been fully answered hereinabove.

17. Respondent denies each and all of the allegations contained in Paragraph Eight of the complaint.

18. Respondent denies each and all of the allegations of Paragraph Nine of the complaint.

Wherefore, Respondent prays (1) that this cause be dismissed for want of jurisdiction; (2) subject to Respondent's motion to dismiss for want of jurisdiction, and only in the event that the same shall have been overruled, Respondent prays that this complaint be dismissed for want of substantial merit; (3) that the proposed order set out in the complaint be not entered, Respondent having shown cause by this answer (the allegations of which answer will be supported by substantial proof at the hearing) why such order should not issue.

Respectfully submitted, J. D. Wheeler, Attorney of Record for Respondent The American Hospital and Life Insurance Company.

Address: J. D. Wheeler, 1603 Alamo National Building, San Antonio 5, Texas.

[fol. 34] Before Federal Trade Commission

Minute Entries

Notice of Prehearing Conference, dated 11/24/54;
Notice of Hearing, dated 12/10/54;
Motion for Continuance, dated 12/16/54;
Order of Federal Trade Commission, dated 12/16/54 Cancelling Hearing;
Notice of Hearing, dated 4/13/55;
Supplemental Notice of Hearing, dated 5/10/55;

Motion to have Compilation of Pertinent Statutes submitted by Counsel supporting the Complaint admitted into the record as Commission Exhibit No. 58;

Order of Federal Trade Commission, dated 7/7/55 granting motion for admission into the record of Compilation of Statutes;

Omitted from the Printed Record, pursuant to Petitioner's Designation as to Printing Record, copied at page 1.

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[fol. 35] BEFORE FEDERAL TRADE COMMISSION

RESPONDENT THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY'S MOTION TO DISMISS NO. 2.—Received July 22, 1955.

To Honorable J. Earl Cox, Hearing Examiner:

Now comes The American Hospital and Life Insurance Company, by its Attorney of Record, and after Counsel supporting the complaint have rested the case in chief in support of the complaint, and before Respondent has offered any evidence and without waiving Respondent's motion to dismiss contained in Respondent's answer heretofore filed, Respondent moves the Commission to dismiss the complaint upon the following grounds:

The jurisdiction of the Federal Trade Commission, insofar as it is pertinent to the complaint filed herein, is limited to preventing unfair or deceptive acts or practices *in commerce*. (emphasis ours) None of the material [fol. 36] charged in the complaint as being to the prejudice and injury of the public and as constituting unfair and deceptive acts and practices ever moved in interstate commerce. The evidence is undisputed that none of this material ever moved across state lines except from the home office of Respondent to its branch offices in other states; the evidence being undisputed that at no time was any of this material sent by the home office of Respondent to any prospect in any other state.

The evidence is further undisputed that any handling of the material by any representatives of the Respondent

was wholly within the boundaries of the particular state in which said representatives operated.

Wherefore, it being undisputed that none of the material complained of having ever moved in interstate commerce, the Commission is without jurisdiction and the complaint should be dismissed for want of jurisdiction.

Premises Considered, Respondent prays that the complaint in this cause be dismissed for want of jurisdiction.

The American Hospital and Life Insurance Company,
By J. D. Wheeler, Attorney of Record.

[fol. 37] BEFORE FEDERAL TRADE COMMISSION

RESPONDENT THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY'S MOTION TO DISMISS NO. 3.—Received July 22, 1955.

To Honorable J. Earl Cox, Hearing Examiner:

Now comes The American Hospital and Life Insurance Company, by its Attorney of Record, and after Counsel supporting the complaint have rested the case in chief in support of the complaint, and before Respondent has offered any evidence and without waiving Respondent's motion to dismiss contained in Respondent's answer heretofore filed, and moves that the complaint herein be dismissed upon the following grounds:

1. The evidence introduced in support of the complaint is insufficient to establish that Respondent is guilty of making any false or misleading statements or representations with respect to the terms and conditions of its policies, [fol. 38] nor has it been shown that Respondent failed to reveal the limitations of coverage found in such policies, nor has it been shown that any of the material complained of would have the tendency and capacity to mislead or deceive, nor has it been shown that any person has been misled or deceived by any statements or representations made by Respondent.

2. There is no evidence in this record showing that the prosecution of Respondent under the complaint filed herein is in the public interest.

Wherefore, Respondent prays that the complaint herein be dismissed.

The American Hospital and Life Insurance Company,
By J. D. Wheeler, Attorney of Record.

BEFORE FEDERAL TRADE COMMISSION

MINUTE ENTRIES

Memorandum Brief of The American Hospital and Life Insurance Company;

Notice from J. D. Wheeler, Atty., to Division of Legal Records, Federal Trade Commission, dated 7/25/55;

Order of Federal Trade Commission designating date for submission of Proposed Findings, Conclusions and Memoranda, dated 8/2/55;

Brief of Counsel Supporting the Complaint in opposition to Respondent's Memorandum Brief which was filed in [fol. 39] support of Respondent's Three Motions to Dismiss Complaint;

Brief in Opposition to Respondent's Motion to Dismiss;

Appendix "A"—Analysis of Respondent's Advertisements showing States of Distribution and types of Representations as Classified in Brief;

Proposed Findings, Conclusion and Order and the reasons therefor submitted by Counsel supporting the Complaint;

Respondent's Reply Brief to Brief of Counsel supporting the Complaint;

Memorandum by Counsel supporting Complaint discussing Court Decisions mentioned for the first time in Respondent's Reply Brief;

Motion of Respondent, The American Hospital and Life Insurance Company that the original and 10 copies of Respondent's Proposed Findings of Fact and Conclusions of Law be filed, etc.;

Order of Federal Trade Commission receiving into the record Proposed Findings of Fact and Conclusions of Law as if timely filed, dated 10/17/55;

Proposed Findings of Fact and Conclusions of Law of Respondent, The American Hospital and Life Insurance Company;

[fol. 40] Order of J. Earl Cox, Hearing Examiner Closing Proceedings, dated 11/30/55;

Hearing Examiner's Rulings on Proposed Findings and Conclusions;

Omitted from the Printed Record, pursuant to Petitioner's Designation as to printing record copied at page 1.

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BEFORE FEDERAL TRADE COMMISSION

INITIAL DECISION. BY J. EARL COX, HEARING EXAMINER—December 7, 1955

The complaint herein charges that respondent, The American Hospital and Life Insurance Company, has disseminated false, misleading and deceptive statements and representations in advertisements relating to its health-and-accident insurance policies, and, by so doing, has en- [fol. 41] gaged in unfair and deceptive acts and practices in commerce in violation of the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 and 1015), sometimes referred to as the McCarran Act, but adverted to herein as Public Law 15.

Thereafter, respondent filed its answer and, in conjunction therewith, submitted a motion that the complaint be dismissed on the ground that the Federal Trade Commission is without jurisdiction in the matter. This motion was denied for the reason that the question of jurisdiction could be resolved satisfactorily only after evidence in support of the allegations of the complaint had been submitted. Hearings were then held, at which counsel in support of the complaint presented testimony and other evidence, which was duly recorded and filed in the office of the Commission. Respondent rested its case without presenting any additional evidence, renewed its motion to dismiss for lack of jurisdiction and submitted two further motions asking that the complaint be dismissed on the grounds that the acts and practices charged therein are not acts and practices in commerce, that there is insufficient proof in the record to establish that respondent's advertise-

ments are false or deceptive or that respondent has been guilty of unfair or deceptive acts or practices, and that "the further maintaining of the complaint is not in the public interest". Proposed findings of fact and conclusions of law have been submitted.

Some of the general facts are not seriously in dispute. [fol. 42] 1. Respondent, The American Hospital and Life Insurance Company, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Texas, with its principal place of business located in the City of San Antonio. It is authorized by charter to engage in life, health and accident insurance business, and is licensed to conduct such business in the states of Arizona, Arkansas, Colorado, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee and Texas.

2. Respondent maintains, and during the years 1953 and 1954 maintained a substantial course of trade in commerce, as that term is defined in the Federal Trade Commission Act, in health-and-accident insurance business, issuing policies to purchasers thereof located in each of the fourteen states in which it was and is authorized to do business. Among the policies so issued are the following, which are particularly specified in the complaint.[1]

(1) American Family Accident Policy, Form A(1),

(2) American Standard Accident Policy, Form ASA,

(3) All American Accident Policy, Form AAA,

(4) Income Protection Policy, Form A&H 3,

[fol. 43] (5) Business and Professional Men and Women's Income Policy, Form BPI,

(6) Preferred Individual Hospital and Surgical Insurance Policy, Form PRI,

(7) American Economy Hospital and Surgical Insurance Policy, Form AE Rev., and

(8) All American Automobile Accident Policy, Form AAAA.

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[1] There was also introduced into evidence a policy called The American President, Form API, but no charges relating to this policy are are set forth in the complaint, and counsel supporting the complaint do not mention it in their proposed findings.

3. Some of the persons who purchased policies from respondent while living in a state in which respondent was licensed to do business later moved to states in which respondent is not licensed. Nevertheless the insured-insurer relationship has been maintained, the respondent sending premium notices and receipts to these insureds not matter where they live and receiving from them premium payments by mail. To this extent respondent has been engaged in commerce with residents of states other than those in which it is licensed. However, there is no reliable, substantial, probative evidence that original sales were made by responent in states in which it was not licensed, or that respondent's advertising literature, containing the representations charged in the complaint to be false and deceptive, was circulated or used, in states in which it was not licensed, in connection with its renewal business. There were, therefore, no acts or practices in commerce in connection with this renewal business which come within the inhibitions of the Federal Trade Commission Act. Such representations as were made, so far as the evidence in this proceding shows, were made at the time of the original [fol. 44] sale of these policies, and that occurred in states in which respondent was licensed.

4. In connection with and to promote the sale of each of the policies listed above, the respondent prepared and issued a circular or brochure consisting of four pages. There is one exception—the circular relating to policy AE Rev. consisted of a single page. No other form of advertising was used by respondent, and no sales were made by mail. The brochures were sent by respondent from its home office to agents located in the various states in which it was licensed, and were used by them and often shown to prospective purchasers, as aids in selling the policies to which they relate. The first and second pages of each brochure contain advertising matter; the third page consists of an application form, and the last page either is blank or contains information helpful in determining premium rates. Upon completion of a sale the applicant for insurance filled out, or furnished the information for filling out, and signed the application form, which was then torn from the brochure and sent in to the respondent with the proper premium payment; the agent issued a receipt for the premium received, usually on the form at the bottom of the second page of the

brochure, and then left pages 1 and 2 of the brochure with the applicant. Upon acceptance of the application by the respondent, a policy was issued and transmitted to the selling agent for delivery to the insured. This was the usual procedure, as described by an officer of the respondent company, although, as he said, there may have been many variations. He had no direct knowledge of the selling methods actually used by respondent's agents in the field, but, for the purposes of this decision, it is assumed that each of the [fol. 45] brochures containing the statements charged in the complaint to be false and deceptive was shown to some prospective purchasers. No sales were made except through properly licensed agents.

Jurisdiction

It was decided in an early case that Federal Trade Commission jurisdiction must exist at the time of the issuance of an order.

"As the orders of the Commission are purely remedial and preventative, the effect thereof is entirely in the future. Therefore, the jurisdiction of the Commission should, in this respect, be measured as of the time of the order rather than as of the filing of the complaint or as of the hearing thereon." *Chamber of Commerce of Minneapolis, et al.*, v. *Federal Trade Commission*, 13 F 2d 673, 685; 8th Cir., 1926).

More recently, after specific reference to Section 5 of the Federal Trade Commission Act in which unfair or deceptive acts or practices in commerce are declared unlawful and the Commission is "empowered and directed to prevent * * * unfair methods of competition in commerce and unfair or deceptive acts or practices in commerce", another Court said:

"And since the power of the Federal Trade Commission is purely regulatory and not punitive, it is clear that jurdisdiction must exist at the time of the entry of its order. Jurisdiction at the time of the commission of acts objected to as unfair trade practices or at the time of filing of the [fol. 46] complaint with regard thereto is not sufficient; for the order to be entered does not relate to past practices or determine rights as of the time of the filing of the complaint, as in an action at law, but commands or forbids

action in the future" (*United Corporation et al.* v. ***F.T.C.***, 110 F(2d) 473, 4th Cir. 1940).

A determination of jurisdiction at this stage of the proceeding is, therefore, not a final determination, and any facts or events affecting jurisdiction which may occur after the issuance of the initial decision and prior to final order will have to be given consideration at the time of issuance of such final order. But a determination, though tentative, must now be made.

The pertinent provisions of Public Law 15 read as follows:

"*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

"Sec. 2 (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

[fol. 47] "(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law."

Public Law 15 was enacted to allay the considerable unrest and uncertainty which developed in the insurance industry and among officials in the insurance departments of the various states following the decision in *U. S.* v. *South Eastern Underwriters Association*, 322 U.S. 533 (1944), in which the Supreme Court held that insurance business, unless confined to a single state, is commerce as the term

"commerce" is used in the Constitution, the anti-trust laws, and the Federal Trade Commission Act. Prior to that decision, regulation and control of insurance by the states had not been questioned, and they had developed comprehensive regulatory and taxing systems which seemed to be limited only by the jurisdictional aspects of due process. Following the decision, had Congress remained silent, the Federal Trade Commission Act would have been applicable to the business of insurance in the same manner and to the same extent as it is applicable to other businesses in interstate commerce, the precedents of numerous Court decisions [fol. 48] would have been controlling, and Federal Trade Commission jurisdiction in the instant case would be indisputable.

In *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 409 (1946), the Supreme Court was faced with the interpretation of Public Law 15 as it applies to the taxation of an out-of-state insurance company by a state in which that insurance company was doing business under license. In sustaining state 'taxation', the Court laid down principles which are applicable to 'regulation' and are controlling in this case. In its decision, the Court, speaking through Justice Rutledge, said that by enacting Public Law 15, Congress

"* * * clearly put the full weight of its power behind existing and future state legislation to sustain it from any attack under the commerce clause to whatever extent this may be done with the force of that power behind it, subject only to the exceptions expressly provided for"; and "intended to declare, and in effect declared, that uniformity of regulation, and of state taxation, are not required in reference to the business of insurance, by the national public interest, except in the specific respects otherwise provided for * * * "[2]

"Obviously, Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance. This was done in two ways. One was by removing obstructions which might be thought to flow from its own power, whether dormant or [fol. 49] exercised, except as otherwise expressly provided

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[2] *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 409 (1946), p. 431.

in the Act itself or in future legislation. The other was by declaring expressly and affirmatively that continued state regulation and taxation of this business is in the public interest and that the business and all who engage in it 'shall be subject to' the laws of the several states in these respects.[3]

"Moreover, in taking this action, Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed and of the taxes exacted; and of the further fact that many, if not all, include features which, to some extent, have not been applied generally to other interstate business. Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations.[4]

The Court added:

"Nor is it necessary to conclude that Congress, by enacting the McCarran Act, sought to validate every existing state regulation or tax. For in all that mass of legislation must have lain some provisions which may have been subject to serious question on the score of other constitutional limitations in addition to commerce clause objections arising in the dormancy of Congress' power." 4

[fol. 50] Again speaking of Public Law 15, the Supreme Court, in a more recent case,[5] used these words:

"Suffice it to say that even the most cursory reading of the legislative history of this enactment makes it clear that its exclusive purpose was to counteract any adverse effect that this Court's decision in *U.S.* v. *South Eastern Underwriters Association*, 322 U.S. 533, might be found to have on State regulation of insurance."

In another recent case[6] the Seventh Circuit Court, referring to Public Law 15, said:

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[3] *Prudential* case, *supra*, pp. 429-30.

[4] *Prudential* case, *supra*, p. 430.

[5] *Maryland Casualty Company* v. *Cushing*, 347 U.S. 409 at 413 (1954).

[6] *U.S.* v. *Sylvanus*, 192 F.2d 9 67th Cir., 1951, p. 100.

"It is clear, we think, that by this legislation the Congress established a perfect policy upon the part of the National government to refrain from interference with the regulation and taxation of insurance companies by the several States."

The power of Congress over commerce is not limited. It may remain unexercised, or it may be expressed by specific, direct, regulatory legislative enactment, or it may be exercised as in Public Law 15, by recognizing existing regulation by the states. The choice lies with Congress, and the Federal Trade Commission, as a creature of Congress, is bound by Congress' choice.[7]

[fol. 51] Justice Rutledge in the *Prudential* case, *supra*, after pointing out that there has been considerable judicial oscillation in interpreting the commerce clause, noted the trend of judicial thinking as follows:

"[For] concurrently with the broadening of the scope for permissible application of federal authority, the tendency also has run toward sustaining state regulatory and taxing measures formerly regarded as inconsonant with Congress' unexercised power over commerce, and to doing so by a new, or renewed, emphasis on facts and practical considerations rather than dogmatic logistic. * * * For in effect they have transferred the general problem of adjustment to a level more tolerant of both state and federal legislative action".[7]

Following the logic of the *Prudential* case, the conclusion is reached that, under Public Law 15, Federal Trade Commission jurisdiction in the present proceeding is precluded to the extent that the states, in which respondent is licensed to conduct its insurance business, have regulatory statutes applicable to the acts and practices charged in the complaint to be false or deceptive.

All of the fourteen states in which respondent does business have comprehensive licensing statutes. Ten of them, Arizona, Arkansas, Colorado, Indiana, Kansas, Kentucky, Louisiana, New Mexico, Oklahoma and Tennessee, have regulatory statutes identical, or substantially identical, [fol. 52] with the "Model Unfair Trade Practices Bill For

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[7] *Prudential* case, *supra*, pp. 420-421.

Insurance" which was formulated for the specific purpose of meeting the requirements of the proviso clause of Public Law 15. The adequacy of that regulatory statute is unquestioned. It is modeled after the Federal Trade Commission Act and prohibits unfair methods of competition and unfair and deceptive acts and practices in the insurance business.

Missouri has two pertinent regulatory laws, the applicable parts of which are as follows: (Underscoring, except that of headings, supplied.)

Chapter 376, Life and Accident Insurance, of the Revised Statutes of Missouri, 1949:

"376.590. Misrepresentations, false estimates and circulars prohibited—agents—notes to be held until policy delivered.

1. *No life insurance company doing business in this state*, and no officer, director, or agent thereof, *shall issue or circulate*, or cause or permit to be issued or circulated, *any* estimate, illustration, *circular or statement of any sort misrepresenting the terms of any policy issued by it* or the benefits or advantages promised thereby, or the dividends or shares of surplus to be received thereon, or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof.

2. Any person who shall solicit an application for insurance upon the life of another shall, in any controversy [fol. 53] between the assured or his beneficiary and the company issuing any policy upon such application, be regarded as the agent of the company and not the agent of the assured, nor shall any life insurance company or agent sell, discount or otherwise dispose of any note or notes taken for payment of life insurance premium or premiums, before delivering to the applicant, in person, the policy for which said note or notes shall have been given. (5844).

"376.600. Penalty for violating section 376.590.

Any life insurance company which may violate any of the provisions of section 376.590, or which may permit any of its agents or representatives in this state to violate said provisions, *shall have its certificate of authority or license*

to transact business in Missouri revoked by the state superintendent of insurance, and shall be for a period of five years barred from the further transaction of business in this state; and any agent, solicitor or representative in this state of any such insurance company who shall violate any of the provisions of said section shall be deemed guilty of a misdemeanor, and, on conviction thereof, in any court of competent jurisdiction in this state, shall be fined not less than fifty nor more than five hundred dollars for each such offense or imprisoned in the county or city jail for not less than ten days nor more than six months, or by both such fine and imprisonment. (5845).

Chapter 561, Crimes and Punishment:

"561.660. Publication of untrue, misleading or deceptive advertisements—penalty.

[fol. 54] 1. Any person, firm, corporation, or association who, with intent to sell or in anywise dispose of merchandise, securities, service or anything offered by such person, firm, corporation, or association, directly or indirectly, to the public for sale or distribution or with intent to increase the consumption thereof or to induce the public in any manner to enter into any obligation relating thereto or to acquire title thereto or an interest therein, makes, publishes, disseminates, circulates, or places before the public, or causes, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in this state, in a newspaper or other publication or in the form of a book, notice, handbill, poster, bill, circular, pamphlet or letter or in any other way, an advertisement of any sort regarding merchandise, securities, service or anything so offered to the public, which advertisement contains any assertion, representation or statement of fact which is untrue, deceptive or misleading, shall be guilty of a misdemeanor.

2. And shall upon conviction thereof be punished by a fine of not less than twenty-five dollars nor more than five hundred dollars, or by imprisonment in the county jail not less than ten days nor more than ninety days, or by both such fine and imprisonment, providing, that nothing herein shall apply to any proprietor or publisher of a newspaper or magazine who publishes, disseminates,

olates any such advertisement without the knowledge of the unlawful or untruthful nature of such advertisement."

The respondent is bound by the statutes of the State of Missouri. These statutes appear to be adequate to pro- [fol. 55] tect the residents of that state from false, misleading or deceptive insurance advertising practices, and therefore are regulatory of the business of insurance to the extent prescribed by Public Law 15 as being proscriptive of the applicability of the Federal Trade Commission Act.

The same is true of the statutes of the State of Illinois, which, in addition to imposing very stringent licensing requirements including provision for suspension or revocation of license if any law of the state is violated, provided, particularly as to insurance business, as follows:

Smith-Hurd Illinois Annotated Statutes (1954):

"Chapter 73, Section 761: *Misrepresentation and Defamation Prohibited.* (1) No company doing business in this state, and no officer, director, agent, clerk or employee thereof, broker, or any other person, shall make, issue or circulate or cause or knowingly permit to be made, issued or circulated any estimate, illustration, circular, or verbal or written statement of any sort misrepresenting the terms of any policy issued or to be issued by it or any other company or the benefits or advantages promised thereby or any misleading estimate of the dividends or share of the surplus to be received thereon, or shall by the use of any name or title of any policy or class of policies misrepresent the nature thereof.

* * * * * * *

"(5) Any company, officer, director, agent, clerk or employee thereof, broker, or other person who violates any [fol. 56] of the provisions of this section, or knowingly participates in or abets such violation, shall be required to pay a penalty of not less than one hundred dollars, nor more than one thousand dollars, to be recovered in the name of the People of the State of Illinois by the State's Attorney of the county in which the violation occurs and the penalty so recovered shall be paid into the county treasury."

The statutes of the State of Texas with respect to regulation of insurance need not be discussed, inasmuch as all

respondent's business within that State is intrastate business and hence is not subject to regulatory action on the part of the Federal Trade Commission.

Mississippi stands alone, therefore, as the one state in which there is no statute which can be found to be regulatory of false and deceptive acts and practices such as are charged against the respondent in the complaint in this proceeding. The only related statute of Mississippi is in Article 6, Section 5683 (1948) of Title 22 of the State Code, and is as follows:

"Any solicitor, agent, examining physician or other person who shall knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any publication for insurance, or who shall make any such statement for the purpose of obtaining fee, commission, money or benefit in any corporation, transacting business under this chapter, shall be guilty of a misdemeanor, and upon conviction shall be punished by a fine of not less than one hundred dollars, nor more than five hundred dollars, or imprisonment in the county jail for not less than thirty days."

[fol. 57] This statute is not applicable to the respondent corporation, and clearly is inadequate under the proviso clause of Public Law 15 to preclude the applicability of the Federal Trade Commission Act to the allegedly false and deceptive acts and practices in commerce carried on by the respondent with persons living in the State of Mississippi. To that extent the Federal Trade Commission has jurisdiction over the respondent and over the issues raised in the complaint. Conclusions hereinafter reached are based on facts relative to that commerce.

Issues of Fact

The gravamen of the complaint is that the terms and conditions of various policies issued by the respondent do not conform to representations made in the brochures pertaining thereto. Five representations charged to be false and misleading are specifically set forth in numbered subparagraphs of Paragraph Six of the complaint; advertising statements which allegedly support these representations are set forth in Paragraph Five; and the manner in which respondent's policies fail to conform to the repre-

sentations is alleged in Paragraph Seven. The issues of this proceeding are thus clearly defined. No instance of actual deception is shown in the record, and no evidence was offered to indicate how respondent's advertising statements were or might have been interpreted by prospective purchasers of health and accident insurance.

Charge No. 1:

The first charge of the complaint is that respondent has falsely represented "that the indemnification provided by [fol. 58] respondent's policies may be continued to age 60 or for an indefinite period at the option of the insured", and that this is not true because the policies are term policies renewable at the option of the respondent only, and are automatically terminated upon the payment of certain cash benefits.

The advertising statements quoted in the complaint, upon which this charge is based, are:

"No Age Provision terminating or reducing benefits because of increasing age."

"Issued to Men, Women, and Children, Ages 3-60."

"Issued to Men and Women, ages 18 to 60."

The first-quoted statement is from the lower left-hand corner of the first or cover page of a 4-page brochure relating to Policy, form ASA. It appears in the same location on the brochure relating to policy AAA. The statement seems to be perfectly clear and understandable. It states, in language about as simple and concise as can be used, that the policies to which it refers will not be terminated, nor will benefits be reduced, on account of increasing age of the insured. Some health and accident policies are automatically terminated and some provide for lower or reduced benefits after the insured has reached a specified age. Respondent's statement is that its policies contain no such provisions, and an examination of the policies shows that the statement is true. Respondent's policies contain no provision terminating or reducing benefits because of increasing age. There is no evidence in the record to the [fol. 59] contrary, and no showing that respondent has ever canceled a policy or reduced benefits because of the advancing age of a policy-holder.

The second and third statements are partial quotes from boxes outlined in color and conspicuously placed in the lower left-hand corner of the second page of each of the two brochures relating, respectively, to policies A(1) and A&H 3. The boxes are adjacent to or a part of the receipt form, and contain the following texts:

Policy Form A(1) Issued to Men, Women, and Children, Ages 3-60. Only persons engaged in non-Hazardous occupations are eligible and all applicants must be in good health.

Policy Form A&H 3 Issued to Men and Women, ages 18 to 60. Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health.

Similar statements are similarly presented in brochures relating to ASA and other policies. The statements need no interpretation. The language is clear that applicants for the various policies must be within the age limits specified. No reasonable person could ascribe any other meaning to this language as it appears in context. Respondent's policies to which these statements refer are issued to applicants within the specified age limits. No evidence to the contrary was adduced, and the conclusion must be reached that the statements are true. The statements have no reference to the renewability or non-renewability of the policies, nor to the manner in which, or the cause for which, a policy may be terminated.

[fol. 60] None of the statements quoted in the complaint, nor any similar statements contained in other literature circulated by respondent, can be interpreted as making the representation alleged in subparagraph 1 of Paragraph Six of the complaint that "the indemnification provided by respondent's policies may be continued to age 60 or for an indefinite period at the option of the insured". The reliable, substantial, probative evidence of record does not support the misrepresentation charged, and the complaint, as to the first charge thereof, should be dismissed.

Charge No. 2:

The second charge in the complaint, as stated in subparagraph 2 of Paragraph Six thereof, is that respondent has falsely and deceptively represented that its "policies provide indemnification for any or all sickness or illness".

According to Paragraph Seven, this representation relates specifically to policy A&H 3.

The advertising statement upon which the charge is based is from the second page of the brochure relating to respondent's A&H 3 policies, and is quoted in subparagraph 2 of Paragraph Five of the complaint as follows:

"Confining Illness Indemnity for loss of time from illness, beginning on the fourth day and continuing for one year for each illness . . .".

The full text and style of the statement, as it appears in the brochure, follows:

[fol. 61] "Confining Illness Indemnity, $ . . . . . per month for loss of time from illness, beginning on the fourth-day and continuing for one year for each illness. (Up to two months full benefits for nonconfining illness)." The foregoing is one of eight boxed items appearing in two columns on this page, across the bottom of which is the following statement in heavy, blackface type:

"Benefits described above are contingent on recommendation of applicant by an authorized company representative and are subject to the terms of the policy issued."

The format of this brochure is such that all advertising statements relating to the A&H 3 policy, and the premium receipt form, are on the second page; on the front or cover page the copy is general in nature; the fourth page is blank; and page 3 contains only the application form. Thus, all the advertising material can be seen at a glance and can be completely read in less than two minutes.

Any prospective purchaser of the A&H 3 policy who is interested enough to examine the brochure and who may have been attracted by the "Confining Illness Indemnity" bracket must have noticed also the "$ . . . . . per month" phrase, and his curiosity should have been aroused. If he looked at the entire page, he would see the statement across the bottom, that benefits are subject to the terms of the policy. If he were interested at all, it would be natural for him to inquire of the agent selling the policy. Since the law of Mississippi provides a fine and imprisonment for false and fraudulent statements on the part of an [fol. 62] insurance agent, it is assumed that the information which would thus be acquired by a prospective cus-

tomer living in Mississippi would be accurate and to the effect that respondent's A&H 3 policies do not cover all illness.

The question arises as to just how much care a prospective insurance customer must exercise before he selects or enters into an insurance contract. May he rely entirely on a printed advertisement when there is a duly-licensed agent available for questioning? May he select isolated phrases, clauses or sentences from an advertisement and base his conclusions upon his own interpretation thereof without regard to context or surrounding circumstance? Must the interpretation which he adopts be reasonable, or may it be facetious and unrealistic? These questions answer themselves. If the text of an advertisement may be interpreted piecemeal in the manner of the devil quoting Scripture, then reason and sound judgment have no place in the advertising field.

Any reasonably intelligent person considering the purchase of health and accident insurance would be expected to know that health and accident policies do not ordinarily cover all illnesses and all accidents, regardless of their nature or time of origin or occurrence. If by some remote chance he did not so know, respondent's advertisements should alert him to that possibility. Certainly they would have no soporific effect. The statements hereinabove quoted, if read in context by an average person seeking health and accident insurance, would not engender the belief that indemnification would be available in every case of illness. [fol. 63] Furthermore, respondent's brochures were used for many months preceding the filing of the complaint in this proceeding. If there had been cases in which purchasers had been misled into such a belief by the contents of these brochures, that fact certainly could have become known and evidence of actual deception could and should have been presented. Absence of such evidence justifies a presumption that none exists and, although that presumption is not relied upon, the conclusion based upon all the facts relating to the A&H 3 brochure and the manner in which it was used is that the statements contained therein do not support the charge contained in subparagraph 2 of Paragraph Six of the complaint that respondent, by these statements, represents or has represented that its "policies

provide indemnification for any or all sickness or illness".

If it is assumed, *arguendo*, that respondent has made the representation charged, then, before a cease and desist order may issue in respect thereto, it must be established that the representation is false and deceptive in the six aspects set forth in subparagraph 2 of Paragraph Seven of the complaint. These will be considered *seriatim*.

(1) It is charged that not all illnesses are covered by respondent's policies, since benefits are limited to sickness "which shall wholly, necessarily and continuously disable and prevent the insured from engaging in any business, profession or employment and be disabled and strictly and continuously confined in the house and be therein visited and regularly attended by a legally-qualified physician [fol. 64] (M.D.) or surgeon (M.D.) or osteopath other than himself", and "In cases of illness which is non-confining, but otherwise limited as above, indemnification will be limited to two months. No indemnification * * * will be paid for the first three days of disability after the first treatment * * * and no indemnification will be paid except for the period after and during continuous medical treatment".

This qualifying language is in the A&H 3 policies. Counsel supporting the complaint urge that "under such a restriction the owner of a business dare not even make decisions necessary for carrying on his business while he is away. A woman, although necessarily, wholly and continuously confined, might be able to do needlework that could be sold for profit, but to do so would prevent her from collecting on the policy". Respondent's position is that such an interpretation is unrealistic and does not conform to the usual and customary meaning of the language as applied by respondent and as adopted by the Courts, which have held that these and similar provisions are in insurance policies for the purpose of enabling insurance companies to avoid the payment of fraudulent and fictitious claims.

Since jurisdiction in this proceeding rests largely, if not entirely, on that part of respondent's business which is carried on in the State of Mississippi, the law of that state is particularly apropos to the issues in this proceeding.

In *N. Y. Life Ins. Co.* v. *McGehee*, 10 SO 2d 454, 193 Miss. 549 (1942), the Supreme Court of Mississippi said:

[fol. 65] "This Court, in agreement with the majority in other states, has been liberal towards the insured in the interpretation and application of provisions in health policies in regard to total and permanent disability and as to when the disability is such as to prevent the insured from engaging in any occupation or employment for compensation or profit. We have endeavored to give to such provisions a practical and common sense construction, consonant with the equities of the particular case, and to grant relief according to substance rather than form;".

In *World Ins. Co.* v. *McKenzie*, 55 SO 2d 462, 212 Miss. 809 (Dec. 1951), the policy provision which was before the Court for interpretation was similar to that contained in respondent's A&H 3 policies. The facts in the case were that the insured had arthritis which required him to remain inside 75% of the time; the doctor "did not at any time visit the home of the insured" but did prescribe for him. There was evidence that the arthritic condition was incurable.

The Court, in sustaining a judgment for the insured, said that the terms of the policy should be liberally construed to carry out the spirit and purpose of the contract, and that the law will not enforce idle and useless formality, such as requirement of regular attendance of a physician when it can serve no useful purpose. The Court recognized that under a literal interpretation of the policy the insured could not recover, but said that this was not the correct application of the law, and that such provisions must be construed in the light of their purpose, which is to guard against fraudulent claims. The Court, quoting another case with approval, added:

[fol. 66] "When the reason for a contract provision disappears, the provision itself disappears as far as being a material element in the legal problems at hand."

Counsel supporting the complaint cites the case of *American Bankers Ins. Co.* v. *White*, 158 SO 346 (Miss. 1935) as not supporting the contentions of respondent and therefore as contradicting the foregoing decisions. Counsel has misinterpreted the *White* case. In that case the insured, a housewife, had suffered an injury which affected her eyesight. She could not perform her regular household duties, but did some sewing and helped with the cook-

ing. One witness testified that she was totally and permanently disabled. Her attending physician stated that she was partially disabled, and that he had not seen her regularly although she lived next door.

The policy involved in the *White* case contained provisions similar to those involved in the instant case, but it also contained a provision not found in respondent's policies, that:

"Strict compliance on the part of the Insured and Beneficiary with all the terms and conditions of this policy shall be a condition precedent to recovery hereunder, and any failure in this respect shall forfeit to the company all right to any indemnity".

Despite this unusually strong phraseology, the Court referred with approval to the Mississippi cases supporting the proposition that

"It is not necessary that the insured be wholly incapacitated to perform any duty incident to his usual employ- [fol. 67] ment or business, but that if the insured is prevented by his injury or illness from doing the substantial acts required of him in his business or occupation, or if his physical condition is such that, in order to be cured or to prolong his life, ordinary care and prudence require that he cease all work, he is totally disabled within the meaning of such policies".

The Court, referring to the policy provision requiring medical care, said:

"There is no reason why the insured could not have complied substantially with this clause of the contract, and it may have been absolutely necessary from the point of view of the insurer, in order that it might know that the disability was continuing and total."

The Court added that the injury to the eyes might have been relieved and full eyesight might have been restored by proper and constant attention. The Court said that as a matter of law it could not be held that the provision requiring attendance by a physician was not necessary in order to protect the insured against fraud.

The Court did not deny relief to the insured, but said that the question of the need for attendance by a physician was not fully or satisfactorily covered by the proof, and sent the case back for another trial. The *White* case does not contradict the holdings heretofore referred to, which in fact are later decisions, but supports them wholly.

[fol. 68] It is clear that policy provisions as to house confinement, abstinence from business duties, attendance by a physician, and similar phrases are not interpreted by the Courts, particularly by the Courts of Mississippi, as precluding recovery of indemnification for proper claims arising out of accidents or illness. Since the Courts have spoken, their interpretation is controlling, and the conclusion is reached that these provisions of respondent's A&H 3 policy do not constitute a limitation upon the illnesses for which holders of such policies may receive indemnification.

(2) Another phrase of this charge is that indemnification is not provided for any or all illness, inasmuch as in cases of nonconfining illness indemnification is limited to a period of two months. This has all the characteristics of a *non sequitur*. The charge is also founded upon a false premise which arises out of the fact that the complaint contains only a partial quote from respondent's brochure, as hereinabove indicated (p. 13). The omitted parenthetical statement "(Up to two months full benefits for non-confining illness)" is a clear description of the coverage of the policy, and there is no falsity or deception in this respect. It is difficult to understand why this phase of the charge was included in the complaint.

(3) Still another phase of this charge is that indemnification is not provided for any and all illness in that in nonconfining illness no indemnity will be paid for the first three days of disability after the first treatment by a doctor. The brochure clearly indicates that indemnification will begin "on the fourth day". The policy provides that the waiting period shall begin "with the date of the first per-[fol. 69] sonal treatment" by a doctor. This provision is in the policy obviously to discourage fraud. Otherwise any person with an inclination to malinger could feign illness, and there would be no way for the insurer to determine with any certainty whether or not the insured was actually ill. An examination by a doctor and a statement

from him as to the existence of an illness is the one positive way of determining that illness actually exists, and is a reasonable requirement and one that would be expected in any contract involving indemnification. Such a provision is not a contradiction of the statement contained in the brochure, but is a reasonable definition thereof. Neither is it a limitation of illnesses subject to policy coverage. The representation made in respondent's advertising in this respect is therefore not false or deceptive.

(4) It is also charged that respondent's A&H 3 policy has been falsely and deceptively misrepresented as covering any or all illness, whereas indemnification is not provided "in cases of sickness commencing prior to the effective date" of the policy.

Sickness is defined in the policy as meaning "sickness or disease contracted and commencing after the effective date" of the policy. Thus, under the policy, recovery cannot be had for disability due to a condition which existed prior to the effective date of the policy.

It would seem to be fundamental that insurance is purchased to take care of future contingencies. One cannot take out fire insurance to cover the loss of a building which has already burned, nor life insurance to compensate for a death that has occurred; nor accident insurance [fol. 70] to cover an accident which has taken place, nor sickness insurance to cover preexisting illness. If health and accident insurance could be obtained to compensate for pre-existing conditions, no one would procure a policy until after the event—and there would be no such thing as health insurance as that term is now commonly understood.

If the prospective purchaser of respondent's A&H 3 policy had any such misconception of insurance, that misconception should have been dispelled before he had reached the end of the application form; indeed, it should have been dispelled by the statement in the box in the brochure (hereinabove quoted, p. 12), in which it is stated "and all applicants must be in good health". In the application, following specific questions as to approximately 30 different diseases which the prospective insured might have had, there is a general question, "Have you now any disease or disorder?" and still another question asking for the details

as to any accident or sickness for which a doctor may have been consulted within the last five years. In the next-to-the-last question, the applicant is asked if it is understood and agreed that the insurance contract "shall not become effective unless to the best of your knowledge you are in good health on the date of the contract". How anyone could read the brochure and fill out the application form without realizing that the policy would not cover pre-existing illnesses is difficult to understand.

The question of whether a sickness has resulted from a condition which pre-existed the date of the policy is one of fact which, in the absence of fraud, would be interpreted by the Courts in favor of the policy-holder, as is indicated [fol. 71] by the many decisions which follow the logic of the cases hereinabove discussed, and from the general rule that where the language is of doubtful meaning every doubt is to be resolved against the insurer and in favor of the insured.

Counsel supporting the complaint have urged that respondent is obligated by its representations to pay indemnity where a post-policy illness arose out of a condition which pre-existed the policy date if the pre-existing condition was unknown to the insured. Upon direct inquiry by counsel, an officer of the respondent company stated that no claim had ever been denied by respondent where the pre-existing condition was unknown to the insured. To contradict this statement and "for the purpose of showing that the company had interpreted the policy to mean that they could refuse a claim where the pre-existing condition was unknown to the policyholder", counsel supporting the complaint presented in evidence, and urged by brief, the claim of Barbara E. Neal.[8] An examination of this claim discloses that the facts do not contradict the testimony of respondent's officer.

The Barbara E. Neal claim arose out of a tonsillectomy and adenoidectomy performed March 30, 1954, when she was 5 years 7½ months old. The policy was a family policy taken out on Barbara's fifth birthday, August 14, 1953, by her father, George S. Neal, an attorney of Clinton, Mississippi. The policy covered George S. Neal, his wife Bar-

[8] Commission's Exhibits 51A through 51Z1.

bara S. Neal, his daughter Barbara Ellen Neal and his son George S. Neal III. The file indicates that there were at [fol. 72] least two lapses in the policy, which, so far as this record shows, was finally reinstated March 3, 1954. The operation was twenty-seven days later.

The application for the policy contained a specific question as to whether the applicant or any dependent listed therein had then or ever had had any tonsil trouble, to which the applicant replied, "Yes", and, in explanation of this answer, stated that the tonsils of both he and his wife had been removed. No mention was made of any tonsil trouble of Barbara Ellen. In answer to a general question as to medical consultation or treatment, the application shows only that Barbara Ellen and her brother, George S., had been treated for colds by Dr. E. D. Reynolds. In two applications for renewal following the lapses,[9] filed December 7, 1953, and February 15, 1954, there is no mention of any illness of any member of the family.

The statement of the attending physician and authorization for Barbara Ellen's hospital entry was not executed until May 7, 1954, although it presumably refers to facts as of the date of admission, March 30, 1954. The statement is signed by E. D. Reynolds, M.D., and appears to be in his handwriting. He states that he has known this patient all her life, and, in answer to a question as to when the disease was contracted, says, "I have treated tonsils about 2 years". As to whether the disease was acute or chronic, the answer is "Acute—now". The required surgical procedure is checked as major. On May 31, 1954, Doctor Reynolds wrote a letter to respondent's representative in Jack- [fol. 73] son, Mississippi, qualifying these statements to some extent—not denying that he had treated the child for tonsil trouble, but stating that "this condition was one of the normal symptoms of childhood infections which are reflected in inflamed tonsils, sore throat and evidence of otitis media".

The statement of the operating surgeon, Dr. R. H. McArthur, was executed April 2, 1954. It shows that the patient first consulted him March 12, 1954. As to how

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[9] One of these applications for reinstatement was signed "George S. Neal, Jr. by Mrs Geo. S. Neal".

long prior to his first examination the disease had been contracted, he used just one word, "Indefinite". He attributed the origin of the disease to "Recurrent Infection", and classified the disease as "Chronic".

Under these circumstances, it would require an undue extension of the bounds of credulity to believe that the insured did not know at the time of the filing of his application that his five-year-old daughter had theretofore received medical care for tonsillitis and related symptoms. The extensive consideration given this claim supports rather than refutes the statement of respondent's officer that claims are paid by respondent when the insured does not or did not know of pre-existing conditions leading to the sickness for which indemnification is sought.

(5) The fifth respect in which the second representation is alleged to be false and deceptive is that, by the terms of the policy, "if the insured is a female, no indemnity will be provided for loss from pregnancy, childbirth or miscarriage".

[fol. 74] The brochure relating to the A&H 3 policy, which is the only policy to be considered under the allegations of this part of the complaint, makes no reference whatsoever to pregnancy or any of the possible disabilities that may arise therefrom. The policy itself unequivocally states, "If the insured is a female the policy does not cover death, disability or other loss resulting wholly or directly from pregnancy, childbirth or miscarriage".

The brochure and the attached application specifically refer to accident and sickness insurance. The policy provides benefits for disabilities and losses due to accident or sickness, nothing more. Pregnancy comes under neither classification, and there is a general understanding on the part of the public and particularly of prospective purchasers of insurance that unless pregnancy is specifically mentioned, indemnification for the disabilities and expenses that may result therefrom are not included in an accident-and-sickness insurance policy. A&H 3 accident-and-sickness policies are sold to both sexes between the ages 18 and 60, and are so drawn as to be applicable to contingencies that can happen to both. Pregnancy is not such a contingency. In insurance, a contingency refers to something that may happen at an unpredictable future time, due to un-

known, unexpected or unforeseen circumstances not within the control of the insured. Pregnancy cannot be so classed.

The A&H 3 policy is not a group policy nor a family policy, but strictly an individual policy applicable only to accident and sickness contingencies which the one individual named in the policy may encounter. Unless an individual applicant is one of the large general class and seeks [fol. 75] coverage for contingencies which may occur to all members thereof, he or she should not apply for the A&H 3 policy, but should seek a policy to cover losses for the specific conditions that he or she may anticipate or expect to encounter. Hence it is reasonable to expect, and it is believed to be true, that any female anticipating pregnancy and desiring indemnification in connection therewith will specifically look for insurance policies which relate thereto, and will not expect to be indemnified under a general policy available to the general public regardless of sex, age, or other circumstance.

It would be unreasonable to expect an insurance company to state in their advertising pertaining to a general policy, The Policy to Which This Advertising Relates Does Not Cover Pregnancy. In omitting such a red-flag warning in its brochure relating to its A&H 3 policy, the respondent can not be found to have indulged in any false and deceptive misrepresentation. Again attention is called to the fact that this is the brochure which carries the warning that benefits are subject to the terms of the policy.

(6) The final charge is that the representation is false, in that the A&H 3 policy does not provide indemnity for sickness occurring outside the forty-eight states, the District of Columbia or Canada south of 60° north latitude. There is no such exclusion in the A&H 3 policy, and this portion of the second charge is completely without support.

For the several reasons hereinabove set forth, it is concluded that the charges set forth in subparagraph 2 of Paragraph Six of the complaint have not been sustained by substantial, reliable, probative evidence.

[fol. 76] *Charge No. 3:*

The complaint, in subparagraph 3 of Paragraph Six, alleges that respondent has represented that its policies "provide indemnification for all or any accidents", and in sub-

paragraph 3 of Paragraph Seven, charges that "respondent's policies BPI (1-52), A&H3-1949, and AAA (1-50), the policies concerning which the representation set out in subparagraph 3 of Paragraph Five was made, do not provide indemnification for all cases of accidental injury. On the contrary, indemnification is provided only when such injury shall, commencing within twenty days after the date of the accident, at least, continuously disable and prevent the insured from performing one or more important daily duties pertaining to his occupation and while under regular medical care".

The issue is thus definitely limited to the three policies listed, and the truth or falsity of the representation made is to be determined by comparison of the statements contained in the brochures with the provisions of the three policies.

In subparagraph 3 of Paragraph Five, five advertising statements, referred to herein as (a), (b), (c), (d) and (e), are quoted, which, with other statements of similar import and meaning, constitute respondent's representation herein charged to be false and deceptive. The five quoted statements are:

(a) "It Will Pay Medical Costs For Accidents".

(b) "Pays You a Monthly Income when you are disabled because of accident * * *".

[fol. 77] (c) "Covers Accidents".

(d) "Pays from First Day of disability for each accident * * *".

(e) "Monthly Indemnity For Loss of Time by Accidents".

Quotation (a) is from the brochure relating to policy A(1); (d) is from the brochure relating to policy ASA. These quoted statements will therefore be disregarded, but other statements of "similar import and meaning" are found in the brochures relating to policies BPI, A&H 3 and AAA, and will be considered. Quotations (b), (c) and (e) are from the brochure relating to policy AAA, but are only partial quotes and out of context.

(c) is from a diagonally-placed, green-shaded box (about 2½ × 5¾" in size) across the upper half of the first or cover page of the AAA brochure. It is printed in large

type with distinctive green ink, in contrast with the other copy on that part of the page, which is in black ink. The box is a solid green-lined rectangle, bordered by green scallops. It is conspicuous. The full text is:

Covers Accidents (24 pt.).
Subject to Policy Terms (12 pt.)

(Type size indicated in the parentheses.)

Pays From First Day of Disability House Confinement Not Required Legal Reserve Protection.

[fol. 78] (b) is part of the first paragraph of descriptive material in the lower left-hand corner of the first or cover page of the same AAA brochure, appearing under the heading "Important Features Of This Plan". The full text of the paragraph follows:

"Pays you a monthly income when you are disabled because of accident, *according to terms of policy.*"

In (c) and (b) directly above, the emphasis is supplied to indicate the context phrases which are omitted in the quotations set forth in the complaint.

(c) is from the upper part of the second page of the same AAA brochure, and is the heading of a paragraph which, in its entirety, is as follows:

"Monthly Indemnity For Loss of Time By Accidents Pays from First Day of disability for Life while you are totally disabled. Pays 40% of monthly income up to three months, for partial disability."

No statements are quoted in subparagraph 3 of Paragraph Five of the complaint from the BPI and the A&H 3 brochures, which are practically identical. The A&H 3 brochure has previously been described. In each of these two brochures all the advertising material is on one page, across the bottom of which is the two-line statement in 12-point heavy type,

"Benefits * * * are subject to the terms of the policy issued".

If the two context clauses "subject to policy terms" and "according to terms of policy" from the cover page of the [fol. 79] AAA policy and the 12-point heavy-type sentence

above quoted from the BPI and the A&H 3 brochures are disregarded, the conclusion may be reached that respondent has represented that the three policies do provide indemnification for all or any accidents. But if these clauses are read and given equal credence with the other advertising material in conjunction with which they appear, no such conclusion is possible. The question again arises as to just how much and what part of an advertisement may be disregarded by a prospective purchaser of insurance.

An insurance policy is a contract. To set forth in a readable advertisement all the terms and provisions of that contract is a practical impossibility. All an advertiser can do is to call attention to the main features of the contract and, by appropriate language, red-flag any important qualifications or conditions. This the respondent has attempted to do in the three brochures here involved. The red-flagging has been done in a way which should attract the attention of any fair-minded, conscientious reader, and no such reader would be led to believe, from respondent's advertising, that the AAA, BPI, and A&H 3 policies cover, without exception, "all or any accidents". He would be on notice to seek further information.

As respondent's business was conducted, means of enlightenment were readily available. The brochures were handed to prospective customers by respondent's salesmen-agents. There was no general distribution. The application form is attached to and a part of each brochure and contains a provision that each applicant's signature [fol. 80] thereon must be witnessed by the salesman. The premium receipt form is likewise a part of each brochure. The applicant must be recommended by an authorized company representative. Under these circumstances every sale must result from a personal interview in which each prospective purchaser has full opportunity to discuss, inquire about and get full information concerning any policy in which he may be interested. It is therefore difficult to justify a finding that such a purchaser would be deceived or misled by a single phrase, clause, or sentence selected at random and out of context.

Insurance is not a tangible thing that can be seen, or pictured, or adequately described in a few words. A prospective purchaser cannot approach the buying of insurance

as he would the purchase of a pair of shoes, a garment, a piece of furniture or an article of food. It is common knowledge that an insurance policy should be read carefuly, and that those provisions in which the purchaser is especially interested should be checked thoroughly. This is not an endorsement of the principle of *caveat emptor*, but does mean that the prospective purchaser should have a definite understanding of, or procure an informed interpretation of, any insurance policy before he buys it. The Federal Trade Commission is enjoined by law to prevent unfair and deceptive acts and practices in commerce, but it is not required to be legal adviser to or personal guardian of every such prospective purchaser.

There is ample warning in respondent's brochures to alert any reasonably intelligent person to the fact that re- [fol. 81] spondent's BPI, AAA and A&H 3 policies do not attempt to provide full indemnification for *all* accidents under *all* circumstances. If a purchaser were unaware of that fact as a matter of common knowledge, he should have been made aware of it by the content of respondent's brochures.

Assume, arguendo, that the representation alleged in subparagraph 3 of Paragraph Six is supported by the statements contained in respondent's advertising. It is a fact that each of the three policies contains a provision to the effect that indemnification for total disability will be provided as stated in the AAA policy "when the injury shall, commencing within 20 days after the date of the accident, wholly, necessarily and continuously disable and prevent the insured from performing each and every duty pertaining to his occupation". The partial disability clause is phrased slightly differently, the expression "one or more important daily duties pertaining to his occupation" being substituted for the more restrictive "each and every duty" of the total disability clause. Identical or similar language appears in the BPI and A&H 3 policies.

As indicated in the discussion of Charge No. 2, above, the Courts put a very liberal interpretation on insurance terminology, and limit the restrictive, technical provisions of insurance policies to such reasonable interpretations as will protect the insurer from fraud, yet give the insured indemnification for all legitimate claims. The general rules laid

down in the cases cited above are applicable here. The language of the clause quoted in the complaint and contained in the policies, thus reasonably interpreted, does not con-
[fol. 82] stitute a limitation in contradition of the alleged representation here under discussion. Under such circumstances, this charge of the complaint must fail for lack of support by substantial, reliable, probative evidence.

Charge No. 4:

The charge of subparagraph 4 of Paragraph Six of the complaint is that policy AE Rev. 9-52, the policy referred to by the representation set out in subparagraph 4 of Paragraph Five, provides for the payment of $150.00 for any operation serious enough to justify such a surgeon's fee. The advertising statement quoted in subparagraph 4 of Paragraph Five is:

"Surgery from $3.00 to $150.00, Depending on seriousness of operation".

Proof of the falsity of this statement, the complaint states in Paragraph Seven, is shown by the fact that "policy AE Rev. 9-52 provides for the payment of $150 for surgeons' fees for only six out of sixty-seven different listed operations. For twenty-nine of the listed operations, $25 or less is allowed".

The single-page advertising sheet referring to respondent's AE Rev., policy contains the advertising statement quoted above, but it takes a high degree of imagination to read into that statement the alleged representation that the policy to which it refers would provide "$150 for any operation serious enough to justify such a surgeon's fee". It can only be interpreted to mean that 150 is the maximum fee that will be paid for even the most serious operation,
[fol. 83] and that payments ranging from $3.00 to $150.00 will be made in proportion to the seriousness of the operation.

If the interpretation stated in the complaint were accepted, there would be very few operations paid for by insurance companies which would not be claimed to be serious enough to justify a surgeon's fee of $150.00. The interpretation urged in the complaint cannot be accepted as a reasonable interpretation of the language used, nor as one

which would occur to any prospective purchaser who would read respondent's advertising sheet in which the statement appears.

Furthermore, there is no evidence in the record and no basis in general experience or common knowledge for reaching any conclusion as to what is a proper fee for any operation. A schedule in respondent's policy indicates what amounts will be paid for specific listed operations, but the fact that the policy provides for the payment of $150.00 for only six out of sixty-seven listed operations and $25.00 or less for twenty-nine is, in itself, not proof of the falsity of the representation charged against respondent in this part of the complaint, and this is the only respect in which the advertising with regard to respondent's AE Rev. policy is alleged to be false, misleading and deceptive.

The charges in the complaint as set forth in subparagraph 4 of Paragraph Six thereof fail, therefore, because they are not supported by substantial, reliable, probative evidence, and the complaint as to them should be dismissed.

[fol. 84] *Charge No. 5:*

The last charge of the complaint is based on the contents of the same advertising sheet, and refers to the same AE Rev. policy as one involved in Charge No. 4.

The charge is that in its advertising statements the respondent has represented that this policy "provides for the payment of maternity benefits in addition to payments for room service and hospital expense", and that this representation is false because the policy does not so provide, but pays maternity benefits "in lieu of all other benefits provided by said policy for hospital services". The advertising statements quoted in the complaint are:

"Room Service . . . Hospital Expense . . . Surgery . . . Additional Benefits . . . Maternity . . ."

More than one-half of the upper portion of the single-page advertising sheet pertaining to the AE Rev. policy is occupied with three, starred, 24-point, block-type headings and the text appertaining thereto. The headings are:

"* Room Service," "* Hospital Expense," "* Surgery", The "*Surgery" text has been hereinabove referred to, and is the one quoted in full in the complaint, in support of

Charge No. 4; the "* Room Service' heading is followed by a one-line statement "31 days each entry"; "* Hospital Expense" is amplified by seven numbered items followed by a summarizing statement:—"Any service of the hospital necessary to the recovery of the patient".

[fol. 85] Lower down on this page, in 18-point script type, is the heading "Additional Benefits", and under this are four sub-headings:

"Ambulance Service, Maternity, Emergency Hospital Service, Accidental Death, Dismemberment or Loss of Sight Before Age 65".

Under the "Maternity" sub-heading is the following:

"Up to $ ..... after insurance has been in force 10 months.

The AE Rev. policy is a hospital and surgical insurance policy, and does not cover maternity benefits except by a supplemental rider which may be attached thereto. This rider provides:

"The company agrees to pay a sum not exceeding ten times the daily amount stipulated in the policy for room service for actual charges made for hospital services resulting from pregnancy including childbirth or miscarriage *in lieu of all other benefits provided in the policy for hospital services*" (emphasis supplied).

The part in *italics* is emphasized in the rider by being printed in heavy, blackface type. Specific amounts are set out for Caesarian operation, for extra-uterine abdominal operation, and for miscarriage.

It would seem to be clear that the meaning of the rider is that the respondent pays in maternity cases the specified amounts for hospital and surgical procedures resulting [fol. 86] from pregnancy, and that such payments in no way affect respondent's liability to pay the amounts prescribed in policy AE Rev. for hospitalization and surgery due to other causes. Maternity benefits are thus in addition to those provided by the policy itself, and this is what the advertisement states; hence there is no misrepresentation.

If the interpretation suggested in Paragraph Six of the complaint and urged by counsel in support of the complaint were accepted it would mean that an insured in a pregnancy case would recover the benefits provided therefor in the rider plus the benefits provided in the policy for non-maternity cases. To postulate such an interpretation ideas and concepts which are foreign to the actual printed matter would have to be interpolated into respondent's advertising. Such an interpretation would not normally occur to a prospective purchaser and would be an unjustified basing of inference upon inference.

Charge No. 5 of the complaint should be dismissed as not supported by substantial reliable, probative evidence.

Conclusions

The Federal Trade Commission has jurisdiction in this proceeding to the extent hereinabove stated. The proceeding is in the public interest. The allegations of the complaint charging the respondent with making false and misleading statements and representations with respect to the terms and conditions of its policies in general or with respect to the terms and conditions of specific policies have not been established by substantial, reliable, probative [fol. 87] evidence. Accordingly, it cannot be found that the respondent has violated the Federal Trade Commission Act by engaging in unfair and deceptive acts and practices in commerce to the prejudice and injury of the public. Therefore,

It Is Ordered that the complaint herein be and the same hereby is dismissed.

J. Earl Cox Hearing Examiner.

December 7, 1955.

Mailed Dec. 15 1955, Legal Records.

[fol. 88]

Before Federal Trade Commission

Notice of Intention to Appeal—December 19, 1955

Joseph Gallaway and William R. Kearney, counsel supporting the complaint hereby give notice of their intention

to appeal to the Commission from the initial decision of the hearing examiner which was served on them December 15, 1955.

Joseph Callaway, William R. Kearney, Counsel Supporting the Complaint.

Dated this 19th day of December 1955.

Mailed Dec. 21, 1955, Legal Records.

[fol. 89] BEFORE FEDERAL TRADE COMMISSION

MINUTE ENTRIES

Appeal Brief of Counsel in Support of the Complaint:

Request to the Commission for Oral Argument by Counsel supporting Complaint;

Motion of Respondent, The American Hospital and Life Ins., Co., to extend time for filing its brief in reply to appeal brief of counsel in support of the Complaint;

Notice of Robert M. Parrish, Secretary of Federal Trade Commission, dated 2/2/56 relative to time and place for argument, etc.;

Order of Federal Trade Commission, dated 2/7/56 extending time for filing of Answering Brief;

Answering Brief of The American Hospital and Life Ins. Co.;

Motion of Respondent, The American Hospital and Life Insurance Co., to include Mississippi Law in Record;

House Bill No. 145 enacted by the 1956 Legislature of the State of Miss.;

Omitted from the Printed Record, pursuant to Petitioner's Designation as to printing record copied at page 1.

* * * * * * * *

[fol. 90] BEFORE FEDERAL TRADE COMMISSION

Findings as to the Facts, Conclusions and Order—Issued April 24, 1956

Commissioners: John W. Gwynne, Chairman, Lowell B. Mason, Robert T. Secrest, Sigurd Anderson, William C. Kern.

Pursuant to the provisions of the Federal Trade Commission Act, the Federal Trade Commission, on October 14, 1954, issued and subsequently served upon respondent, The American Hospital and Life Insurance Company, a corporation, its complaint, charging said respondent with the use of unfair and deceptive acts and practices in commerce in the sale of health and accident insurance policies, in violation of the provisions of the Federal Trade Commission Act.

Thereafter, respondent filed its answer and, in conjunction therewith, a motion for dismissal of the complaint on the ground that the Commission is without jurisdiction in the matter. This motion having been denied by the hearing examiner duly designated in the complaint, [fol. 91] for the reason that the question of jurisdiction could be resolved satisfactorily only after the submission of evidence, certain testimony and other evidence in support of the allegations of the complaint were introduced before the hearing examiner and were duly recorded in the office of the Commission. No further evidence having been presented by respondent, the matter was considered by the hearing examiner upon the complaint, respondent's answer thereto, the testimony and evidence, proposed findings as to the facts and conclusions presented by counsel, and additional motions for dismissal, filed by respondent, and the hearing examiner, on December 8, 1955, filed his initial decision in which he ordered that the complaint be dismissed.

Within the time permitted by the Commission's Rules of Practice, counsel in support of the complaint filed an appeal from said initial decision, and the Commission, after considering said appeal, respondent's brief in opposition thereto, oral arguments of counsel, and the entire record herein, rendered its decision granting the appeal and vacating and setting aside the initial decision.

Thereafter, this matter came on for final consideration by the Commission, and the Commission, being now fully advised in the premises, makes the following findings as to the facts, conclusions drawn therefrom, and order, which, together with the aforesaid decision on the appeal shall be in lieu of the initial decision of the hearing examiner.

[fol. 92] FINDINGS AS TO THE FACTS

1. Respondent, The American Hospital and Life Insurance Company, is a corporation, duly organized, existing and doing business under and by virtue of the laws of the State of Texas, with its principal place of business located at Pecan & St. Mary's Streets in the City of San Antonio, State of Texas. Said respondent is authorized by charter to engage in, and it does engage in, the business of life, health and accident insurance. It is licensed to conduct such business in the States of Arizona, Arkansas, Colorado, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee and Texas. Respondent's life insurance business is not involved in this proceeding.

2. Respondent maintains a substantial course of trade in commerce as that term is defined in the Federal Trade Commission Act, in health and accident insurance, issuing policies to purchasers thereof located in each of the fourteen States in which it is authorized to do business. Among the policies so issued are those for individuals and family groups identified by respondent as follows:

(1) American Family Accident Policy, Form A (1).

(2) American Standard Accident Policy, Form ASA.

(3) All American Accident Policy, Form AAA.

(4) Income Protection Policy, Form A&H3.

[fol. 93] (5) Business and Professional Men and Women's Income Policy, Form BPI.

(6) Preferred Individual Hospital and Surgical Insurance Policy, Form PRI.

(7) American Economy Hospital and Surgical Insurance Policy, Form AE Rev.

(8) All American Automobile Accident Policy, Form AAAA.

The substantiality of respondent's busines is indicated by the fact that its premium receipts from its health and accident insurance business during the year 1953 was $4,835,523.05 and during the year 1954 was $5,009,184.47.

3. Respondent's health and accident insurance business is conducted through agents in the various States in which respondent is licensed. When an agent in any State other than Texas secures an application for a policy, the application is sent through the mail by the agent to respondent's home office in San Antonio, Texas, where the policy is issued. The policy is then mailed back to the agent in the other State for delivery to the purchaser.

4. A substantial number of persons who have purchased policies of health and accident insurance from respondent while living in States in which respondent was licensed to do business have later moved into States in which respondent was not so licensed. It is respondent's practice in such cases to mail to such insureds or policyholders premium notices and recepits and to receive from them [fol. 94] premium payments renewing the coverage afforded by their policies. Premium payments so received by respondent from States other than those in which it was licensed to do business for the year 1953 amounted to $47,305.72, and for the year 1954 amounted to $78,417.89. To this extent respondent is regularly engaged in commerce with residents of States other than those in which it is licensed to do business.

5. In connection with and to promote the sale of each of the policies listed in paragraph 3, above, respondent prepares and issues a circular or brochure consisting of four pages. There is one exception—the circular relating to the policy Form AE Rev. consists of but a single page. The brochures are sent by respondent from its home office in San Antonio, Texas to its agents located in the various States in which respondent is licensed, and are used by such agents, and often shown by them to prospective purchasers, as aids in selling the policies to which they refer. The first and second pages of each brochure contain advertising matter; the third page consists of an application form; and the last page either is blank or contains information helpful in determining premium rates. Upon completion of a sale, the applicant for insurance fills out, or fur-

nishes the information for filling out, and signs the application form, which is then torn from the brochure and sent in to respondent with the proper premium payment; the agent issues a receipt for the premium received, usually on the form at the bottom of the second page of the brochure, and then leaves pages 1 and 2 of the brochure with the applicant. Upon acceptance of the application at its home office, respondent issues the policy and trans- [fol. 95] mits it to the selling agent for delivery to the insured.

6. In the brochure relating to respondent's policy, Form ASA, the following advertising statements are made:

"No Age Provision terminating or reducing benefits because of increasing age," and

"Policy Form ASA issued to Men and Women, ages 18 to 60. Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health."

The same statements are made in the brochure relating to the policy, Form AAA.

The complaint alleges that through the use of these statements, respondent represents that the indemnification provided by its policies may be continued to age 60 or for an indefinite period at the option of the insured. Such representation is false, the complaint charges, because respondent's policies are term policies and are renewable at the option of respondent only. Further, the policies are automatically terminated upon the payment of certain cash benefits.

The Commission does not construe these statements as having the meaning ascribed to them. Said statements can be reasonably read to mean only that the policies contain no provisions terminating or reducing benefits on account of increasing age and that applicants for such policies must be within the age limits specified; and the evidence is that the statements as so construed are both true. [fol. 96] On this phase of the case the allegations of the complaint have not been sustained.

7. In the advertising section of the brochure relating to respondent's policy, Form A&H3, the following, among other boxed items, appears:

"Confining: Illness: Indemnity: $ ..... Per Month. for loss of time from illness, beginning on the fourth day and continuing for one year for each illness. (Up to two months full benefits for non-confining illness.)"

Substantially similar statements are made in the brochure relating to respondent's policy, Form BPI. The record shows that the blank amount of dollars is usually filled in by the agent before or at the time he is talking to the prospect, based on the premiums paid.

Through such statements, respondent represents, directly and by implication, that its policies provide indemnification for loss of time due to any and all sickness or illness.

In truth and in fact, respondent's policies do not so provide. The coverage under the policy, Form A&H3, is expressly restricted to indemnification for loss of time due to sickness or disease contracted and commencing after the effective date of the policy and while the policy is in force which wholly, necessarily and continuously disables and prevents the insured from engaging in any business, profession or employment for wage or profit and only for such period of time as the policyholder is regularly visited and [fol. 97] attended by a legally qualified physician (M.D.), surgeon M.D.) or osteopath, other than himself. Nor does the policy cover loss of time for illness due to pregnancy, miscarriage or childbirth in case of a woman policyholder, regardless of how long the policy has been in effect. The policy, Form BPI, also contains substantially the same restrictions on respondent's liability, none of which restrictions are disclosed in the sales brochures.

Respondent's representations as to the indemnification provided by its policies for loss of time due to sickness or illness are, therefore, false and deceptive.

8. Respondent's brochure relating to its policy, Form BPI, also contains the following with respect to loss of time due to accidents:

"Total Accident Disability: $ ..... Per Month for loss of time from accidental injury, beginning with the first day of disability and continuing for life while you are totally disabled." and

"Partial Accident Disability: $ ..... Per Month for loss of time from accidental injury, beginning with the first

day and continuing for the period of partial disability (limit 3 months)."

Substantially the same statements are also made in the advertising sections of the brochures relating to respondent's policies, Forms A&H3 and AAA.

Through such statements, respondent represents, directly and by implication, that its policies provide indemnification for loss of time due to all or any accidents.

[fol. 98] In truth and in fact, respondent's policies do not so provide. Under the policy, Form BPI, respondent's liability for loss of time due to total accident disability is limited to accidents that shall within twenty days after the date of the accident wholly, necessarily and continuously disable and prevent the insured from performng each and every duty pertaining to his occupation for the first twelve months. After that time, the insured, in order to collect the indemnity, must be wholly and continuously disabled by reason of the accident from engaging in any occupation for wage or profit. Futhermore, the policy expressly limits the company's liability for loss of time due to either total or partial accident disability to such periods of time as the policyholder is under the regular care of a legally qualified physician (M. D.), surgeon (M. D.) or osteopath, other than himself. The policies, Forms A&H3 and AAA, contain similar limitations on respondent's liability, none of which limitations is disclosed in the sales brochures.

Respondent's representations as to the indemnification provided by its policies for loss of time due to accidents are, thus, false and deceptive.

9. Respondent's advertising brochure for its policy, Form AE Rev., contains the following:

"*Room service
31 days each entry
*Hospital Expense
1. Operating Room
2. Anaesthetics
[fol. 99] 3. Laboratory Service
4. X-Rays
5. Dressings
6. Drugs
7. Blood transfusions

Any service of the hospital necessary to the recovery of the patient.

Surgery

From $3.00 to $150.00 $150.00

Depending on seriousnes of operation.

Additional Benefits

* * * Maternity: Up to $ after * * * insurance has been in force 10 months. * * *"

Through such statements, respondent represents, among other things, that said policy provides indemnity up to a maximum sum of $150 for any operation serious enough to cost such an amount, and that the maternity benefits mentioned are in addition to payments for room service and hospital expenses.

Actually, the policy does not so provide. Under the terms of this policy, payment for surgeon's bill is in accordance with a schedule of fixed fees for different types of operations. Only six out of sixty-seven operations listed call for a surgeon's fee of as much as $150. For twenty-nine of [fol. 100] the listed operations, the surgeon's fees allowed are $25 or less, regardless of the actual cost of such operations to the policyholder.

Said policy likewise does not provide for the payment of a maternity benefit after ten months, or at any other time, in addition to the payments provided for room service and other hospital expenses. The maternity benefit is obtainable only by payment of an additional premium over and above the regular premium provided in the policy and is covered by a supplemental agreement or rider attached to the policy. Moreover, said supplemental agreement or rider expressly provides that payment of the maternity benefit shall be "in lieu of all other benefits provided in the policy for hospital services," and it is, thus, clear that the maternity benefit, instead of being an additional benefit, as represented is merely a substitute.

Respondent's representations to the contrary are false and deceptive.

Conclusions

1 The Federal Trade Commission has jurisdiction over all of the respondent's acts or practices alleged in the complaint to be unlawful

2. The public interest in the proceeding is clear and substantial.

3. The use by respondent of the statements and representations, found herein to be false and deceptive, with respect to the terms and conditions of its policies of insur- [fol. 101] ance, and its failure to reveal the limitations of the coverage of said policies, have the tendency and capacity to mislead and deceive a substantial portion of the purchasing public into the erroneous and mistaken belief that said statements and representations are true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

4. The aforesaid acts or practices of respondent as above set forth are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act.

ORDER

It Is Ordered that respondent, The American Hospital and Life Insurance Company, a corporation, and its officers, agents, representatives, and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication:

1. That said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided are set forth conspicuously, prominently, and in sufficiently close conjunction with said representation as will fully relieve it of all capacity to deceive.

[fol. 102] 2. That said policy provides for payment in full or in any specified amount or for payment up to any specified amount for any medical, surgical or hospital service, unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented, or unless full disclosure of the sched- [fol. 103] ule of payments for which the policy provides is made conspicuously, prominently, and in sufficiently close

conjunction with said representation as will fully relieve it of all capacity to deceive.

3. That said policy provides for the payment of certain benefits in addition to other benefits when such is not the fact.

It Is Further Ordered that the respondents herein shall, within sixty (60) days after service upon them of this order, file with the Commission a report in writing setting forth in detail the manner and form in which they have complied with the order to cease and desist.

By the Commission. Commissioners Gwynne and Mason dissenting.

(S.) Robert M. Parrish, Secretary.

Issued: April 24, 1956.

S.A., R.T.S., L.B.M., W.C.K., J.W.G.

Attached is Majority Opinion of the Commission.

Attached is Joint Dissenting Opinion of Commissioners Gwynne and Mason, and Additional Views of Commissioner Mason.

[fol. 104] BEFORE FEDERAL TRADE COMMISSION

Commissioners: John W. Gwynne, Chairman, Lowell B. Mason, Robert T. Secrest, Sigurd Anderson, William C. Kern.

Docket No. 6237

In the Matter of:

The American Hospital and Life Insurance Company, a corporation

OPINION OF THE COMMISSION—April 24, 1956

By Kern, Commissioner:

Counsel in support of the complaint issued in this proceeding has appealed from the hearing examiner's initial decision, in which, after holding that Public Law 15 of the 79th Congress (McCarran-Ferguson Insurance Regulation Act)[1] limit the Federal Trade Commission's jurisdiction herein to respondent's activities in the State of Mississippi, he dismissed the complaint for failure of proof.

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[1] 59 Stat. 33 (1945); 15 U.S.C. 1011ff.

Respondent, a Texas corporation, is licensed to conduct, and does conduct, a health-and-accident insurance business in Arizona, Arkansas, Colorado, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee, and Texas. It sells its [fol. 105] health-and-accident insurance policies exclusively through licensed agents in each of those States, and its only advertising consists of printed brochures, which it mails from its home office in San Antonio, Texas, to its agents in other States for display or distribution to prospective policyholders in the course of sales interviews. Applications secured by respondent's agents in States other than Texas are mailed to respondent's home office, where the policies are issued and mailed to the agents for delivery to the new policyholders. The complaint alleged that respondent's advertising contains various false, misleading and deceptive representations in violation of the Federal Trade Commission Act. Respondent maintains that all States in which it carries on its operations have laws that forbid it or its agents to make misrepresentations in the course of selling its insurance and that under the McCarran-Ferguson Act this is sufficient to remove it from the scope of the Federal Trade Commission Act.

Thus at the threshold of our consideration of this appeal we face an important jurisdictional question. The basis of the hearing examiner's holding that the Commission's jurisdiction extends to respondent's transactions in Mississippi alone is that each of the other States where it advertises or sells its insurance policies (saving from consideration respondent's home State of Texas, inasmuch as jurisdiction has not been asserted over respondent's business transacted wholly within that State) fully regulates the business of insurance by legislative enactment and that to the extent such regulation exists our jurisdiction has been withdrawn by the McCarran-Ferguson Act.

[fol. 106] That statute [2] directly and expressly provides

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[2] The McCarran-Ferguson Act reads in full text as follows:

An Act to express the intent of the Congress with reference to the regulation of the business of insurance.

Be it enacted by the Senate and House of Representatives

that after January 1, 1948, the Federal Trade Commission Act shall apply to the business of insurance "to the extent that such business is not regulated by State law." In the judgment of the examiner, the Commission's jurisdiction over the commercial activities of insurance companies is contingent upon an absence of State regulatory legislation. Implicit in that view is the proposition that the sum of jurisdiction—State and Federal—over commerce is no more than the aggregate of the several State jurisdictions. We need scarcely point out that such a concept not only neglects the exclusive Federal jurisdiction over commerce *among* the States, conferred by Section 3 of Article 1 of the Constitution of the United States, but is inconsistent with the fundamental constitutional doctrine of the separation of State and Federal powers.

[fol. 107] We do not think that the McCarran-Ferguson

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of the United States of America in Congress assembled, That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Sec. 2(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Sec. 3. (a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of

Act, considered solely by its terms or along with its legis-
[fol. 108] lative history and judicial interpretation, admits of such a construction.

In *United States* v. *South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944), the Supreme Court in effect overturned *Paul* v. *Virginia*, 75 U.S. 168 (1868), and the line of related cases, all of which were bottomed on the principle that contracts of insurance are not commerce, either interstate or *intra*state, and declared that the conduct of fire insurance business across State lines is "Commerce among the several States" and accordingly a conspiracy to monopolize interstate trade and commerce in that business vio-
[fol. 109] lates the Sherman Antitrust Act. At the same time the Court pointed out that, for constitutional purposes, certain activities of a business may be *intra*state and hence subject to State control, while other activities of the same business may be interstate and subject to Federal regula-

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October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Sec. 4. Nothing contained in this Act shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

Sec. 5. As used in this Act, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

Sec. 6. If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.

tion. However, the Court did not attempt to decide which State laws were applicable to the business of insurance and to what extent they were not applicable. A local insurance company which sold only within the State was clearly subject to the State laws, but the extent to which a company doing an interstate business was subject to State laws was not made clear.

The McCarran-Ferguson Act was enacted this year following *South-Eastern Underwriters*. Its title states that it is an act to express the intent of Congress with reference to the regulation of the business of insurance. The title does not suggest that Congress was undertaking to give any additional jurisdiction to the States or to take any away; it indicates rather an intent to avoid any ambiguity arising out of the Congressional silence. It appears that the McCarran-Ferguson Act was designed to permit the States to regulate, *in the traditional manner*, the business of insurance. It was not designed to permit insurance companies to secure new business by false or misleading advertising in interstate commerce, nor was it intended as an abdication of Federal jurisdiction under the Sherman, Clayton, and Federal Trade Commission Acts over the business of insurance. Had Congress desired to remove the business of insurance from the scope of these laws, it could have done so by simply providing that for the purpose of those statutes the business of insurance across State lines should not be [fol. 110] deemed to be "Commerce among the several States." Quite to the contrary, it expressly applied those laws to the business of insurance within certain limits.[3]

[3] The original version of the McCarran-Ferguson Act, as reported by the committees of the respective Houses of Congress, provided flatly that neither the Federal Trade Commission Act nor the Robinson-Patman Act should "apply to the business of insurance or to acts in the conduct of that business." In debate on the floor of the House the wisdom of such an exclusion was questioned (91 Cong. Rec. 1027), and the Chairman of the House Committee on the Judiciary offered to propose to the Joint Committee of Conference the elimination of the exclusionary section and the inclusion of the Federal Trade Commission Act in the moratory section, thus making the Federal Trade Commission Act applicable to the insurance business, along with

The first section of the Act declares that "the continued regulation and taxation by the several States of the business of insurance is in the public interest," and that "silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." "Continued regulation" again conveys the idea that Congress did not intend to give anything to the States that they did not [fol. 111] already possess. Silence on the part of Congress was not to be construed as imposing any barrier to State regulation. That is not to say, however, that there were to be no *other* barriers to or limitations upon State regulation: areas in which the States could never regulate were not dealt with one way or the other.

In construing the meaning of this section, it is to be borne in mind that under the commerce clause of the Federal Constitution Congress not only has exclusive power to regulate interstate commerce but in exercising that power can even regulate *intrastate* activities which affect interstate commerce. *United States* v. *Wrightwood Dairy Co.*, 315 U.S. 110, 119 (1942). When Congress enters this intermediate zone and legislates fully on a given subject, the Federal statute, "*ipso facto*, supersedes existing state legislation on the same subject." *Southern Ry. Co.* v. *R. R. Comm., Indiana*, 236 U.S. 439, 446 (1915).

The first section must therefore mean that the continued regulation and taxation by the States of the business of insurance *to the limits of their constitutional power* is in the public interest. Certainly the States lack the power to tax or regulate purely interstate activities of insurance companies. It can only be that the section provides that State authority over *intra*state insurance business that might affect interstate insurance business could not be disturbed by Federal legislation which did not specifically mention insurance.

[fol. 112] We now approach the determination of the proper construction of the crucial second section of the

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the Sherman and Clayton Acts, after 1947. No opposition to this proposal was voiced on the floor. The conference committee adopted the suggestion, with the result that the Federal Trade Commission Act was to apply to the business of insurance upon lapse of the moratorium.

McCarran-Ferguson Act. Subsection (a) thereof makes the business of insurance and everyone engaged therein "subject to State laws relating to the regulation or taxation of such business." This is a clear pronouncement that the *South-Eastern Underwriters* case does not dislodge State regulation of insurance.

The second section goes on to provide in subsection (b):

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance: * * *

Obviously, this does not purport to give the States the power to legislate outside their jurisdiction. Nor does it interfere in any way with Federal laws covering interstate commerce over which the States could not ever claim jurisdiction, e.g., the postal statutes. See *United States v. Sylvanus*, 192 F.2d 96, 100 (7th Cir. 1951), *cert. denied* 342 U.S. 943 (1952). Such laws cannot impair or supersede State laws, for they do not relate to the same channels of commerce. And, under the terms of the Act, they become inoperative only if and to the extent that they impair, invalidate, or supersede State laws. *Maryland Casualty Co. v. Cushing*, 347 U.S. 409, 413 (1954).

[fol. 113] Section 2(b) continues:

Provided, That after January 1, 1948, * * * the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Even without such a proviso the Federal Trade Commission Act would have been applicable to those aspects of the business of insurance which are exclusively in interstate commerce, for that area was never reached by State law. They could not, therefore, be "regulated by State law." Moreover, if this proviso meant only that no action could be taken under the Federal Trade Commission Act which was in conflict with State law it was wholly unnecessary. The statute already had stated that no Act of Congress shall invalidate, impair, or supersede a State law unless it relates specifically to insurance. It is the office of a proviso "to except something from the operative effect or to qualify or restrain the generality of the substantive enactment to which it is attached." *Cox v. Hart*, 260 U.S. 427, 435 (1922).

The proviso in the McCarran-Ferguson Act must therefore make the Federal Trade Commission Act an exception to the rule that no Federal law not relating specifically to insurance may supersede a State law enacted for the purpose of regulating the business of insurance. It must have been contemplated that under certain conditions the Federal Trade Commission Act might supersede a State law purporting to regulate the business of insurance but not covering all aspects thereof. In its application to the interstate phase of a transaction which cannot be regulated by State law, for example, the Federal law in one sense would [fol. 114] supersede a State law covering the same subject matter in a different and local phase of the transaction.

The Federal and State laws in this field supplement and reinforce one another in order to provide full protection to the public. Indeed, it seems to us that such a view is not only consonant with but imperative to the preservation of the public interest in this domain. We fully subscribe to the principle that the Federal Government ought not encumber the State in wielding the maximum of their sovereign powers over the business of insurance. This we understand to be the essential aim of the McCarran-Ferguson Act. But, in the absence of a far stronger and more positive commandment than that statute lays down, we cannot be persuaded that, as to the business of insurance, the Federal authority has been ousted from the interstate regulatory sphere. It surely could not have been the Congressional intent to create a legal vacuum wherein an insurance company would have been enabled to escape regulation of the interstate aspects of its business in cases in which the Federal and State laws did not conflict.

We observe that Section 3(a) of the McCarran-Ferguson Act is a moratory clause suspending the application of the Federal Trade Commission, Sherman, Clayton, and Robinson-Patman Acts to the business of insurance for nearly three years. If those statutes were not to "apply *to the business of insurance* or *to acts in the conduct thereof*" until January 1, 1948, we think it logically follows that they were to apply to that business and to those acts after the prescribed date. Thus this subsection, as well as Section 2(b), is inconsistent with any notion that the Commis- [fol. 115] sion's jurisdiction over the interstate aspects of the insurance business was repealed.

In withdrawing Federal jurisdiction under the Federal Trade Commission, Sherman, Clayton and Robinson-Patman Acts over the business of insurance for nearly three years, Congress apparently was attempting to eliminate arguments by insurance companies that Federal regulation alone was adequate and that State regulations were burdening interstate commerce. Congress gave the States about three years in which to define a reasonable area of State police power. Beyond that reasonable area States could not go. Regardless of whether a State regulated insurance during this time, after 1947 the Federal Trade Commission was expressly authorized to regulate it on different grounds, namely, regulating the use of the interstate channels of commerce.

Since the Court in the *South-Eastern Underwriters* case had said that insurance sold by a company in one State to a customer in another State was in interstate commerce, this type of transaction was subject to the jurisdiction of the Commission. During the moratorium, Congress intended that the Commission not exercise its jurisdiction. After that period the Federal State Commission Act was again to apply, to the extent that the business of insurance was not regulated by State law. Since the States were given no new jurisdiction, State law could regulate the business of insurance only to the extent possible before the *South-Eastern Underwriters decision.* And, as the Court recognized in that case, there were elements of interstate trans- [fol. 116] actions which the States could not regulate.[4]

The legislative history of the McCarran-Ferguson Act supports the foregoing conclusion. We believe this legislative history shows plainly that in enacting that measure Congress was concerned only with ensuring that State laws regulating the business of insurance should not be superseded in the zone of "affecting interstate commerce" by Federal legislation not expressly relating to insurance.

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[4] "The power granted to Congress [by the Commerce Clause] is a positive power. It is the power to legislate concerning transactions which, reaching across state boundaries, affect the people of more states than one;—to govern affairs which the individual states, with their limited territorial jurisdictions, are not fully capable of governing." 322 U.S. at 552.

Thus we find in the reports of the committees of both Houses of Congress this statement:

Inevitable uncertainties which followed the handing down of the decision in the *Southeastern Underwriters Association case,* with respect to the constitutionality of State laws, have raised questions in the minds of insurance executives, State insurance officials, and others as to the validity of State tax laws as well as State regulatory provisions; thus making desirable legislation by the Congress to stabilize the general situation.

Bills attempting to deal with the problem were considered in both the House and the Senate during the Seventy-eighth Congress, but failed of enactment. Your committee be- [fol. 117] lieves there is urgent need for an immediate expression of policy by the Congress with respect to the continued regulation of the business of insurance by the respective States. Already many insurance companies have refused, while others have threatened refusal to comply with State tax laws, as well as with other State regulations, on the ground that to do so, when such laws may subsequently be held unconstitutional in keeping with the precedent-smashing decision in the *Southeastern Underwriters case,* will subject insurance executives to both civil and criminal actions for misappropriation of company funds. [Sen. Rep. No. 20, 79th Cong., 1st Sess., 1-2; H.R. Rep. No. 143, 79th Cong., 1st Sess, 2]

But authority to regulate the interstate aspects of the business of insurance was to remain with the Federal Government, as can be seen from the following statement in the House Committee report, which was quoted with approval by Senator McCarran in floor debate on the bill (91 Cong. Rec. 1443);

It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the *Southeastern Underwriters Association* case. Briefly, your committee is of the opinion that we should provide for the continued regulation and taxation of insurance by the States, subject always, however to the limitations set out in the controlling decisions of the United States Supreme Court, as, for instance,

in *Allgeyer* v. *Louisiana* (165 U.S. 578), *St. Louis Cotton Compress Co.* v. *Arkansas* (260 U.S. 346), *and Connecticut* [fol. 118] *General Insurance Co.* v. *Johnson* (303 U.S. 277) * * *. [H.R. Rep. 143 79th Cong., 1st Sess., 3.]

The three cases last cited in the foregoing excerpt all hold that a State's power to tax insurance activities is limited to transactions occuring within its boundaries. We would be hard put to account for the reference to these decisions if the purpose of the McCarran-Ferguson Act were to substitute an exclusive State power for the Federal Trade Commission's jurisdiction over the interstate aspects of the insurance business.

We are confirmed in our belief to the contrary by the decision of *United States* v. *Sylvanus*, 192 F.2d 96 (7th Cir. 1951), *cert. denied* 342 U.S. 943 (1952), wherein the Court held that the McCarran-Ferguson Act did not abolish Federal jurisdiction under the postal laws to prosecute for mail fraud committed in the sale of insurance in a State having its own statutes regulating that business. The Court carefully distinguished the interstate and *intra*state aspect of the defendant's deceptive practices:

> It can not properly be said that this indictment has to do with the regulation of insurance business in Illinois. Rather it has to do with the question of whether defendants have used the mails in pursuance of a scheme so to manipulate their authorized regulated business in Illinois as to result in fraudulent deception of its prospective policy holders. The charge is not that the corporate charter should be ignored or that the administrative officers of Illinois may not perform their statutory duties and supervise and [fol. 119] regulate the company's insurance business in Illinois, but goes to the use of the mails, over which the Congress has, by the Constitution, paramount power and authority. It matters not that the alleged fraudulent actors might be prosecuted under the law of Illinois. The indictment charges simply that acts of deception amounting to a scheme to defraud have been committed by defendants, in conducting their authorized business, and that defendants have availed themselves of the mails in execution or attempted execution of that scheme. It is immaterial that the fraudulent plan itself is outside the jurisdiction of Congress, *Badders* v. *U.S.*, 240 U.S. 391 * * *, or that the

scheme charged involved a transaction forbidden by the laws of the state. *O'Hara* v. *U.S.*, 6 Cir., 129 F. 551.

We conclude, then, that it was not the intent of the Congress, by its passage of the McCarran Act, to surrender control of the use of the mails or to cease to authorize the federal Courts to determine whether the mails have been utilized in attempted execution of a scheme to defraud and that the District Court, by entertaining jurisdiction, did not interfere with regulation of the insurance company by the state but properly overruled the motions to dismiss the indictment. [192 F.2d at 100.]

Unlike the Federal Trade Commission Act, the postal laws were not expressly brought by the McCarran-Ferguson Act to bear on the business of insurance. Indeed, that statute declares that *no* Act of Congress not specifically relating to the business of insurance shall be construed to invalidate, impair, or supersede any State law regulating that business. Yet in the *Sylvanus* decision, *supra*, the Court held that a postal statute banning a course [fol. 120] of conduct which in its *intra*state aspects constituted a State offense was unaffected by the McCarran-Ferguson Act.

All the more, then, under the Federal Trade Commission Act, which the McCarran-Ferguson Act made applicable to the business of insurance, there must remain an irreducible area of Commission jurisdiction over the interstate activities of insurance companies which cannot be reached by State law and as to which the limitation "to the extent that such business is not regulated by State law" is inoperative.

A State can revoke an insurance corporation's charter or license, thus affecting interstate commerce to some degree. To the extent necessary to enable it effectively to exercise its police power, the State can take action having consequences in other jurisdictions, and the Federal Trade Commission could not prohibit such regulation. And the text and history of the McCarran-Ferguson Act leave no doubt that the power of the States to tax, or to fix rates for, insurance companies doing business within their territories was in no way to be invalidated, impaired, or superseded by Federal law. However, as we have already said, our preceeding to abate deceptive practices by such

companies does not impinge on those State functions, and we do not believe that the Federal Trade Commission Act, when read in conjuction with the McCarran-Ferguson Act, can be properly interpreted to interfere with the taxing or rate-fixing powers.

By executing its statutory mandate to prevent deceptive practices in the interstate business of insurance, the Commission in no wise usurps State laws prohibiting false advertising. The Federal Trade Commission Act and the State laws are both designed to suppress deception in advertising. The Commission's action in the instant matter [fol. 121] aids the States in their own local procedures to protect their citizenry from such excesses. The McCarran-Ferguson Act was passed to enable them to continue such regulation. *Maryland Casualty Co.* v. *Cushing*, 347 U.S. 409, 413 (1954).

The principle that the Commission may proceed against a practice that may simultaneously be the object of State regulation is one of long standing.[5] Thus the Commission's orders prohibiting the interstate shipment of lottery devices to be used in selling merchandise have been universally upheld on judicial review despite the fact that such devices are not put to their intended use until they have left the channels of interstate commerce (just as the respondent's brochures are not displayed for sales purposes until they have come to rest in the hands of respondent's agent within a State). See *Seymour Sales Co.* v. *FTC*, 216 F. 2d 633, 635-6, (D. C. Cir. 1954), *cert. denied* 348 U. S. 928 (1955), and cases therein cited. The idea of a field of enforcement divided between Federal and State Governments is embedded in a number of statutes, in addition to the McCarran-Ferguson Act. Examples of these are Acts dealing with the sale of liquor (the Wilson Act, 26 Stat. 313, and the Webb-Kenyon Act, 33 Stat. 699), convict-

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[5] As recently as April 2, 1955, the Supreme Court of the United States reaffirmed this principles in *Pennsylvania* v. *Nelson*, 350 U.S. . . ., declaring that where the Federal Government had occupied the field of protecting against sedition, States were not thereby prevented "from prosecuting where the same act constitutes both a Federal and a State offense under the police power * * *."

[fol. 122] made goods (the Hawes-Cooper Act, 45 Stat. 1084, and the Ashurst-Sommers Act, 49 Stat. 494), oleomargarine (32 Stat. 193), diseased plants (44 Stat. 98), black bass (64 Stat. 845), whaling (49 Stat. 1246), prizefight films (54 Stat. 686), and the Federal Power Act (49 Stat. 838).

In view of our foregoing consideration of the terms, legislative history, and judicial interpretation of the McCarron-Ferguson Act, we do not think the statute admits of the construction placed on it by the hearing examiner.

Respondent points out that it did not send its advertising materials to sales prospects but mailed them to its own agents in various States for local use, and that hence its advertising occurred only in *intra*state commerce. We consider such an analysis fictitious and unrealistic. Respondent's annual premium collections on health-and-accident insurance sold by its agents throughout fourteen States amount to about $2,750,000. It employs an indisputable channels of interstate commerce, the mails, for sending advertising materials to its agents, receiving applications for insurance from them, and forwarding the issued policies to them for delivery to policyholders. The actual interview of a prospect, though it necessarily happens at a fixed geographical point within some State, cannot be isolated from the remainder of respondent's established course of dealing. By preparing its brochures and furnishing them, by mail, its agents in various States for their use in sales presentations, respondent engages in an interstate commercial practice that must be viewed as a whole and not [fol. 123] compartmentalized. *Consolidated Manufacturing Co.* v. *FTC*, 199 F. 2d 417, 418 (4th Cir. 1952).

Under the Federal Trade Commission Act, one who sells through agents in other than his home State must answer for deceptive advertising which he supplies to his agents, even though such representations are by necessity conveyed to the public within a particular State. *General Motors Co.* v. *FTC*, 114 F.2d 33, 36 (2d Cir. 1940); *Ford Motor Co.* v. *FTC*, 120 F.2d 175, 183 (6th Cir. 1941).

The Commission is accordingly of the opinion that the hearing examiner erred in not holding that the Commission had jurisdiction over such of respondent's practices in interstate commerce as might be found to be unfair or

deceptive, irrespective of the existence of State statutes applicable to the *intra*state elements of such practices.

We turn now to the appeal from the hearing examiner's dismissal of the complaint for lack of substantial evidence.

Respondent was charged with falsely representing, among other things, that the indemnification provided by its policies might continue to the age of sixty, or for an indefinite period, at the option of the insured. The sole evidence adduced on this allegation consists of brochures which states as follows, or similarly:

No Age Provision terminating or reducing benefits because of increasing age,
and—
Policy Form ASA Issued to Men and Women, aged 18 to 60.

Only persons engaged in non-hazardous occupations are eligible and all applicants must be in good health. [fol. 124] We do not believe that these two statements, separately or together, particularly in the absence of assertions of lifetime duration or any other definite period of coverage, can be reasonably read as meaning more than that respondent's policies contain no provisions terminating or reducing benefits on account of increasing age and that applicants for such policies must be within the age limits specified. It is true that respondent's accident-and-health policies are term contracts renewable at the option of the company on the premium date. However, nothing to the contrary is expressed or reasonably implied in the aforequoted statements, and we therefore discern therein no capacity or tendency to deceive. We uphold the hearing examiner's dismissal of the complaint in this respect.

Respondent was next charged with falsely representing that its policies provide indemnification for all illness or accidents. To prove this charge there were introduced respondent's brochures containing broad, general representations, of which the following are typical:

Confining Illness Indemnity $ Per Month for loss of time from illness, beginning on the fourth day and continuing for one year for each illness. (Up to two months full benefits for non-confining illness:)

Total Accident Disability ..... per month for loss of time from accidental injury beginning with the first day of disability and continuing for life if you are totally disabled.

Partial Accident Disability ..... per month for loss of time from accidental injury, beginning with the first day and continuing for period of partial disability (limit 3 months).

[fol. 125] In conjunction with the foregoing there were introduced copies of respondent's policies containing conditions substantially limited the illness and accident benefits advertised. The examiner found that the charges in this regard were not supported by substantial evidence, not for the reason that the representations were not proved nor that the terms of the policies did not materially limit the advertised benefits, but for a number of other reasons which are in our judgment unsound and contrary to controlling precedent.

The examiner attached great weight to the fact that the brochures in question included a statement to the effect that benefits therein described "are subject to the terms of the policy issued." We are not in accord with the examiner's view that such a notice is sufficient to correct erroneous impressions given by the representations "Confining Illness Indemnity—$ ..... per month for loss of time from illness, beginning on the fourth day and continuing for one year for each illness," or "Total Accident Disability—$ ..... per month for loss of time from accidental injury, beginning with the first day of disability and continuing for life while you are totally disabled." Respondent's vice-president, W. C. Murphy, testified that an agent's sales kit consisted of a sales brochures, a rate book, "and, I guess, a fountain pen," and that respondent's agents are not required to carry sample policies with them. These sales brochures consist of an application form and a receipt form for the initial payment. These facts lead us to believe that many applicants do not see sample policies before executing formal applications for respondent's insurance. We consider this circumstance significant. In the context of the sales presentation, in the course of [fol. 126] which the prospect has little or no opportunity

to inspect a sample policy, the sales brochure, we are convinced, clearly has the tendency and capacity of misleading as to the extent of coverage. We disagree with the examiner's statement that if the prospect would read the entire page he would see that all benefits are subject to the terms of the policy and then if interested he would naturally inquire of the agent as to the terms. Rather it is our view that the brochure functions as a self-contained piece of advertising that of itself is likely to induce a prospect to purchase respondent's insurance.

Furthermore, we do not believe that the prospective purchaser is under any obligation to investigate the extent to which respondent's unrestricted representations of coverage for illness or accidents are untrue. "Under repeated decisions, the purchaser is entitled to rely upon the respresentations made. He need not distrust what is told him. * * * It goes without saying almost that it is extremely difficult for a layman to understand the terms and conditions of such policies as these, but whether the applicants did or did not read and understand the policies is beside the point." *United States* v. *Sylvanus*, 192 F.2d 96, 105 (7th Cir. 1951) *cert. denied* 342 U.S. 943 (1952).

If the busy or careless businessman is entitled to protection from deceptive printed forms, even though an attentive, careful person would not be deceived thereby, *Independent Directory Corp.* v. *FTC*, 188 F. 2d 468, 470, 471 (2d Cir. 1951), it does not devolve upon respondent's prospects to ascertain the extent to which respondent's advertising may or may not exaggerate or falsify. The Federal Trade Commission Act is violated if the first contact or interview is secured by deception even though the true facts [fol. 127] are made known to the purchaser before he enters into the contract to purchase. *Carter Products, Inc.* v. *FTC*, 186 F. 2d 821, 824 (7th Cir. 1951).

Another questionable premise in the examiner's reasoning is that "any reasonably intelligent person considering the purchase of health and accident insurance would be expected to know that health and accident policies do not ordinarily cover all illnesses and all accidents, regardless of their nature or time of origin or occurrence." Apart from the fact that the Federal Trade Commission has the duty to protect not only the "reasonably intelligent" but

also the ignorant, the unthinking, the credulous, and the inexperienced, *Charles of the Ritz Dist. Corp.* v. *FTC*, 143 F. 2d 676, 679 (2d Cir. 1944), we question whether the fact asserted by the examiner to be common knowledge—if it be a fact—is generally known even to the "reasonably intelligent." It is certainly not beyond the realm of actuarial conceivability, not to say possibility, that in these United States in the mid-twentieth century insurance could be written which would afford protection against all illness and all accidents.

The examiner noted that no proof of actual deception was offered and declared, "Absence of such evidence justifies a presumption that none existed." Despite his disclaimer of reliance on such a presumption, it evidently was one of the considerations impelling him to dismiss these charges. This is manifest error. It was firmly established long since that actual deception of the public need not be shown in Federal Trade Commission proceedings and that representations having a capacity to deceive are unlawful. [fol. 128] *Charles of the Ritz Dist. Corp.* v. *FTC*, *supra* 143 F. 2d at 680.

The initial decision devotes considerable space to three decisions of the Supreme Court of Mississippi, all involving private litigation, in which that Court accorded a more liberal interpretation to the conditions contained in accident and health policies similar to those here than their literal intendment would seem to justify. He concludes from these holdings that the conditions are not so burdensome as to render untrue respondent's broad representations.

The decisional law of a single State is no sure guide to the interpretations that other States may place on respondent's policies. What is more, the fact that a policyholder may eventually prevail over a respondent in an appeal from a jury trial does not rectify the deception inhering in the sales practices whereby he was induced to purchase the insurance. He may be discouraged by the literal terms of the policy from seeking legal redress. We do not consider that the fact that if he perserver-s to his State Supreme Court he may succeed in winning an interpretation of respondent's policy more favorable to him than the language literally warrants is a substitute for the protection assured him by the Federal Trade Commission Act.

The hearing examiner discusses at some length the reasonableness of the restrictions that respondent attaches to its illness and accident benefits. This is, of course, not germane to the question of whether respondent's representations tend to deceive and mislead.

There remain for discussion two other charges dismissed by the examiner. It was alleged that respondent had rep- [fol. 129] resented its hospital-and-surgical-expense policy to provide for the payment of $150 for any operation serious enough to justify such a surgeon's fee. The evidence shows that respondent disseminates a one-page advertisement which, among other things, states that the policy provides for—

Surgery from $3.00 to $150.00 $150.00
depending on seriousness of operation.

The policy to which this refers sets out a long schedule of the various amounts payable for specified types of surgical operations. Sixty-seven different benefits are enumerated. A mere six of these amount to $150: operations for removal of a portion of the lung, removal of kidney, removal of a portion of the vertebra, removal of entire prostate or thyroid gland, and cutting into the cranial cavity.

Only $25 is allowed for removal of tonsils and adenoids. Appraising this advertisement as it is likely to be read by unsuspecting, incautious members of the purchasing public, we gain the impression that the policy will indemnify up to a maximum sum of $150 for any surgical operation serious enough to cost such an amount. Thus, if a tonsillectomy cost $50, we would think it reasonable to expect that one insured by the policy would be protected to that extent. The advertisement is therefore deceptive and misleading in that it promises benefits which the policy does not corroborate.

Lastly, it was charged that respondent falsely represented that its hospital-and-surgical-expense policy would pay maternity benefits in addition to room service and hospital expense.

[fol. 130] On the advertisements for this type of policy, following a listing of the benefits of room service, hospital

expense, and surgery, there is shown as one of the "Additional Benefits":

Maternity: Up to $ after insurance has been in force for 10 months.

We would have difficulty in reading the foregoing as anything less than a representation that the maternity benefit is *in addition* to the other benefi-s provided by the policy. In actuality, however, the maternity benefit is provided for in a rider wherein it is specified that the maternity benefit shall be "in lieu of all other benefits provided in the policy for hospital service." Thus, far from being an *additional* benefit, it is only a *substitute*, benefit, and the representation in regard thereto is hence at material variance with the facts. We believe that the type of misconception that such advertising as this can engender in the minds of couples seeking to provide financially for the birth of children is especially vicious. There can be no question that it is a patent deception to describe as "additional" a benefit which excludes participation in other benefits, directly following a broad representation that hospital and surgical expenses are covered.

In view of the foregoing, the initial decision is vacated and set aside, and our findings as to the facts, made on consideration of the whole record including the initial decision, and conclusions and order to cease and desist will be issued in lieu thereof.

Commissioners Gwynne and Mason dissent.

April 24, 1956.

[fol. 131] JOINT DISSENTING OPINION OF CHAIRMAN GWYNNE AND COMMISSIONER MASON—April 24, 1956

We are unable to agree with the views expressed in the majority opinion. The reasons for our dissent are: first, the opinion completely ignores the intent of Congress in adopting Public Law 15 (McCarran Act); second, it would return the insurance business to the uncertainty and confusion which followed the decision in *U. S.* v. *South-Eastern Underwriters Association*, (1944) 322 U. S. 533. It was

to remove this uncertainty and confusion that the McCarran Act was adopted.

Prior to the decision in the *South-Eastern Underwriters* case, regulation of insurance was recognized as a problem for the respective states. This was partly because the Supreme Court of the United States in a long line of decisions from *Paul* v. *Virginia*, 8 Wall. 168, to *New York Life Insurance Company* v. *Deerlodge County*, 231 U. S. 495, had held that the business of insurance was not commerce.

Although the business of insurance was not subject to regulation under the commerce clause, it was universally recognized as a business affected with a public interest. [fol. 132] Consequently, the states found few obstacles to regulating it to the fullest extent and in the manner the respective legislatures though to be for the public good in their particular states. These laws took the form of determining who should engage in the insurance business within the state boundaries, the terms under which the business might be conducted, regulation as to rates to be charged (even to the extent of fixing them, or permitting representatives of insurance companies to do so under state supervision). The right of the states to levy tax and license fees, even discriminating against foreign insurance corporations, was also recognized. See 44 C.J.S. p. 518; *LaTourette* v. *McMaster, Insurance Commissioner*, 244 U. S. 465.

Had these regulations been directed at the usual industry engaging in interstate commerce, many would have run counter to paramount Federal authority. For example, the many discriminatory taxing programs were not in accord with decisions of the Supreme Court relating to interstate commerce generally. Certain state rate regulations were contrary to the philosophy of Federal antitrust laws. No conflict arose, however, because it had been settled that the business of insurance was not interstate commerce.

This does not mean that the insurance business and the states in regulating it were free from all Federal constitutional and statutory provisions. They were, of course, subject to such constitutional restraints as the due process clause, the exclusive right of Congress to establish post office and post roads [*U.S.* v. *Sylvanus* (1951), 192 F. 2(d) 96] and many others. In fact they were, and still are, sub-

ject to all restraints properly imposed by paramount power, [fol. 133] except as that power elects to exempt them.

In regulating insurance, states act under that great reservoir of power known as the police power. There are, of course, jurisdictional limitations on the exercise of that power. It may be directed only at activities within the state. It has never been claimed that the states may operate directly in that phase of regulation known as the flow of commerce. Nor by no stretch of the imagination can it be said that the McCarran Act intended to give any such power.

In 1944 in the *South-Eastern Underwriters* case, the Court reversed its holdings of 75 years standing and concluded that the business of insurance was interstate commerce. It was also specifically held that it was subject to the Sherman Act.

The immediate effect of this decision was to bring the business of insurance and the laws of the various states regulating it under the paramount power of the Federal antitrust laws. Because of the inconsistency previously referred to, this created considerable uncertainty and confusion in the insurance field, of which Congress took immediate cognizance.

Confronted with this emergency, Congress had several alternatives:

(1) It might take no action and allow the antitrust statutes to be superimposed on the existing state systems of regulation and taxation. This would create great confusion as to the legal boundaries between Federal and state control, which confusion could only be lessened, bit by bit, as Courts made decisions on specific problems.

[fol. 134] (2) It might write a comprehensive law for Federal regulation of insurance,—a law which would provide new methods for many matters theretofore handled by the states, and which might make such changes in the application of existing antitrust laws to the peculiar business of insurance as experience had indicated might be necessary.

(3) It might recognize and continue existing or future state regulation by removing the obstacles to that regulation which had been called into being by the decision that the business of insurance was interstate commerce.

Congress chose the latter course and expressed its choice by the adoption of the McCarran Act. The general purpose of this legislation was to meet the problems created by the *South-Eastern Underwriters* case. The plan for meeting this problem is clearly expressed in the law. It may be reduced to a simple statement as follows: The Congress declares that the continued regulation and taxation by the states of the business of insurance is in the public interest and shall remain, with two exceptions, namely, (1) this Act shall not render the Sherman Act inapplicable to agreements to or acts of boycott, coercion or intimidation, and (2) that after June 30, 1948 (but not before), the Sherman Act, the Clayton Act and the Federal Trade Commission Act shall be applicable to the business of insurance, but only to the extent that such business is not regulated by state law. Thus, in any case, the jurisdictional question may be quickly and certainly resolved by finding the answer to a simple question, namely, is there state regulation to meet the particular problem presented by the facts. [fol. 135] That this is the proper interpretation of the law is indicated by the following: (1) the wording of the statute itself, (2) the legislative history, (3) events which transpired immediately following passage of the law, (4) decisions of the Courts interpreting the McCarran Act.

It is, of course, well settled that the power of Congress under the commerce clause is broad and is also paramount. It includes the right to regulate, or even prohibit, the flow of things across state lines, the right to regulate the instrumentalities by which commerce is carried on, and also the right to regulate activities, wholly within the state, which affect interstate commerce. The power to regulate the so-called flow of commerce covers every species of movement of persons and things, whether for profit or not; every species of communication; every species of transmission of intelligence, whether for commercial purposes or otherwise; every species of commercial negotiations, which, as shown by the established course of business, will involve sooner or later an act of transportation of persons or things, or the flow of services or power across state lines. (See the *Analysis of the United States Constitution* as prepared by the Legislative Reference Service, Library of Congress, and cases cited.)

The great power of Congress to regulate matters wholly within the state but affecting interstate commerce is well settled in *U.S.* v. *Darby* (1944), 312 U.S. 100, in which the Court held that the payment of substandard wages wholly within a state affected commerce and could be prohibited.

Going with these great powers, and a necessary, corollary to them, is the right of Congress to determine where and when these powers are to be used. Thus, it may decline [fol. 136] to exercise certain powers; and it may condition its refusal to exercise them on the fact of regulation by the states.

This is exactly what Congress was seeking to do in the McCarran Act. Much of the fallacy of the reasoning in the majority opinion springs from a refusal to recognize this obvious fact. The majority would decide the issues in this case by applying principles which admittedly were applicable following the decision in the *South-Eastern Underwriters* case. They conveniently ignore the fact that the purpose of the McCarran Act was to prevent the application of these principles.

For convenience, and before discussing the law in detail, the McCarran Act is set out here in full text:

"*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

"Sec. 2 (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

"(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, [fol. 137] or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the

Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

"Sec. 3 (a) Until January 1, 1948 the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

"(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

"Sec. 4. Nothing contained in this Act shall be construed to affect in any manner the ap-lication to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

[fol. 138] "Sec. 5. As used in this Act, the term 'State' includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

"Sec. 6. If any provision of this Act, or the application of such provision to any person, or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those to which it is held invalid, shall not be affected."

While the title to a statute is not, strictly speaking, a part of the law, nevertheless, it is interesting to note that the title is "To express the intent of the Congress with reference to the regulation of the business of insurance."

Immediately after the enacting clause, occurs the following:

"That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, • • •."

This is a clear and positive declaration of Congressional policy, which cannot be read out of the law. It expressly points out the character of state regulation and taxation which is in the public interest. It is the "continued regulation". In the past, the states have done all the regulating so far as the commerce clause was concerned. That was to carry on, with the exceptions expressly provided for, and which will be discussed hereafter. There is nothing in this statement or in the entire Act which justifies the [fol. 139] interpretation that the regulation contemplated was to continue only by the grace of the Federal Trade Commission.

Speaking on this subject in *Prudential Insurance Company* v. *Benjamin*, 328 U.S. 408, the Supreme Court of the United States had this to say:

"Obviously Congress' purpose was broadly to give support to the existing and future State systems for regulating and taxing the business of insurance. This was done in two ways. One was by removing obstructions which might be thought to flow from its own power, whether dormant or exercised, except as otherwise expressly provided in the Act itself or in future legislation. The other was by declaring expressly and affirmatively that continued State regulation and taxation of this business is in the public interest and that the business and all who engage in it 'shall be subject to' the laws of the several States in these respects.

"Moreover, in taking this action Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation; of the fact that they differ greatly in the scope and character of the regulations imposed and of the taxes enacted; and of the further fact that many, if not all, include features which, to some extent, have not been applied generally to other interstate business. Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations.

* * * * * * *

[fol. 140] "* * * it clearly put the full weight of its power behind existing and future State legislation to sustain it

from any attack under the commerce clause to whatever extent this may be done with the force of that power behind it, subject only to the exceptions expressly provided for."

That a declaration of policy by Congress will be given weight by the Courts is well settled. See *U.S.* v. *Darby*, 312 U.S. 100.

Continuing, the statute further provides:

"* * * and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."

Some of the powers granted to Congress by the Constitution are either expressly, or by necessary implication, exclusive and cannot be exercised by the states, even though Congress has taken no action thereon and has remained silent on the subject. The power to declare war is an example. Under the commerce clause, the line between Federal and state authority cannot be so precisely drawn. This is particularly true in the field of state activities which may or may not have a prohibited effect on interstate commerce. The supremacy of the Congress, when properly exercised in this field, is clearly recognized. A difficult problem arises where the powers of Congress are allowed to lie dormant, that is, when Congress is silent on a given subject. Should its silence be construed as a reservation of its power, which will bar any state regulation; or will it be considered as consent to state action until Congress has spoken? This question has arisen many times and has re- [fol. 141] ceived a variety of answers, depending upon the circumstances of the particular case.

The question of silence of Congress is not involved in this case. The Congress evidently thought it might be raised, and intended to make its position clear. The inclusion of the above quoted clause indicates how thoroughly Congress has considered this matter and how determined it was to remove all possible barriers to its declared policy of state regulation.

Section 2(a) provides:

"The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."

When used in this connection, "subject to" means "subordinate to", "obedient to". *Shay* v. *Roth*, Calif. (1923), 221 P. 967; *Davies* v. *City of Los Angeles* (1890), 24 P. 771.

In a long line of cases from *Paul* v. *Virginia* to *New York Life Insurance Co.* v. *Deerlodge County* insurance companies have challenged their subjection to state regulatory or taxing laws. The Supreme Court, however, consistently rejected this defense on the theory that the business of insurance was not interstate commerce.

When the Supreme Court in *South-Eastern Underwriters* reversed its decision, this defense became good, and the business of insurance was subject to state law, only to the [fol. 142] extent that such laws did not interfere with paramount Federal power under the commerce clause. In Section 2(a) Congress clearly showed its intention to remove the barrier of its own paramount power and thus make the business of insurance subject to state laws, notwithstanding the decision in *South-Eastern Underwriters*.

Section 2(b) provides:

"No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon insurance: *Provided*, That after January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law."

Stronger language to give state laws "top billing" could hardly be imagined. The clause beginning with "unless" is particularly significant. While Congress had not legislated directly concerning the insurance business, it had done so with reference generally to interstate commerce and with reference to persons and corporations engaged therein. The antitrust laws are examples. Congress in Sec. 2(b) said none of these laws (except as indicated in the proviso) shall apply to the business of insurance, unless such law specifically relate to insurance. It recognized:

first, that insurance has some problems peculiar to that [fol. 143] industry; second, that many states had adopted regulatory systems tailored to the insurance business in their boundaries; and, third, that any attempt to superimpose the general laws regulating commerce on these systems would create great confusion.

The proviso applies only to the provision immediately preceding it. *Dahlberg* v. *Young* (1950) Minnesota 42 N.W.2nd 570. It provides an exception to the general statement preceding it, which exception is that the three Acts named therein shall, after January 1, 1948, apply to the business of insurance,—but only to the extent that such business is not regulated by state law. This proviso was adopted to answer criticism of the original House bills, which provided simply that certain laws shall not apply to the business of insurance or to acts in the conduct of that business. In other words, in the original bills, the House proposed to wash its hands of the whole matter, regardless of whether any particular state had provided regulation. The final version, which was accepted by the House without objection, simply conditioned Federal withdrawal from the field on the fact that the particular state had provided regulatory laws. In view of the strong stand taken by the House in favor of continued state regulation, it does not seem reasonable that it would have accepted, without question, this final version, if (as claimed by the majority) such version set up concurrent jurisdiction, with the Federal power paramount to the state power.

What Congress had in mind is further illustrated by Section 3(a) which provides that until January 1, 1948, the antitrust laws should in no event apply to the business of insurance. The majority claim that the purpose of this moratorium was to give the states time "in which to design [fol. 144] a reasonable area of state police power. Beyond that reasonable area, states could not go."

That view is based on a misconception of the state police power. That power was reserved to the states by the Constitution. It is not up to the Congress to determine whether it is exercised reasonably. Whether exercised reasonably or not, this power is subject, at all times, to the paramount power of the Federal government under the commerce clause and other constitutional provisions not involved here; and in case of conflict, the question is resolved by

the Federal government and not by the states. The whole purpose of the McCarran Act was to express the Congressional intent that the barrier of paramount power under the commerce clause was to be removed in the event that the states did adopt regulatory laws. The purpose of the moratorium was to give the states time to adopt such laws. Failing to do so in any particular area, the Federal power would still remain.

Section 3(b) provides:

"Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation."

The *South-Eastern Underwriters* case involved a boycott by a number of insurance companies operating in several states. The Congress concluded that the paramount power of the Federal government in such cases should remain. [fol. 145] The fact that Section 3(b) is in the law is a strong argument against the interpretation urged by the majority. If the McCarran Act left the Federal government and the states with concurrent powers (in which the Federal power would necessarily be paramount), why was it necessary to include Section 3(b)?

The legislative history of the McCarran Act strongly supports our interpretation of the jurisdictional feature.

While the *South-Eastern Underwriters case* was pending in the Supreme Court, bills were introduced in the House, providing for the unqualified exemption of insurance from the Sherman and Clayton Acts. Thereafter, and after considering suggestions by representatives of the National Association of State Insurance Commissioners, and also by representatives of the insurance industry, bills were introduced both in the House and Senate, which bills, with some minor modification, eventually became the McCarran Act. In some respects, these bills further limited the control of Congress, as, for example, in the inclusion of the Federal Trade Commission Act. In other respects, the Federal authority was broadened to retain control, in all cases where state regulation did not exist. The law, as finally passed, is clear on this point; regulation shall remain in the states with the exception of the boycott situation, and with the

exception of those situations where a state either did not or could not adopt the necessary regulations.

There is literally no evidence to the contrary. Note the following excerpts from the Senate debate.

[fol. 146] Senator Murdock:

"And it is intended that on the expiration of the moratorium, the Sherman Act, the Clayton Act, and the other acts mentioned will again become effective, except—."

Senator McCarran:

"Except as the states themselves have provided regulation."

Senator Pepper:

"States may determine whether or not the Sherman and other acts become applicable to the business of insurance?"

Senator McCarran:

"Yes."

What was done after the adoption of the McCarran Act indicates that the persons concerned had no doubt about the meaning of the Act. The National Association of State Insurance Commissioners prepared a model code for the regulation of the insurance business in accordance with the directions of Congress. This code has been adopted by a majority of the State legislatures. Other states have adopted laws which in effect are equivalent.

It is difficult to understand why these actions should have been taken if the parties thereto thought that the net result would leave the law as it was just prior to the McCarran [fol. 147] Act, which is the contention of the majority in this case.

The McCarran Act has been considered in four Federal Court cases. In none of them, did the Court experience any difficulty in determining what the McCarran Act meant. In the Sylvanus case, the Court said:

"It is clear, we think, that by this legislation, the Congress established a public policy upon the part of the national government to refrain from interference with the

regulation and taxation of insurance companies by the several States."

In *Maryland Casualty Company* v. *Cushing* (1953) 347 U.S. 409, the Supreme Court said:

"Even the most cursory reading of the legislative history of his enactment (McCarran Act) makes it clear that its exclusive purpose was to counteract any adverse effect that the Court decision in the South-Eastern Underwriters case might be found to leave on state regulation of insurance."

The Court then quotes from House Report No. 143, 79th Congress, 1st Session, as follows:

"It is not the intention of Congress in the enactment of this legislation to clothe the states with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision in the South-Eastern Underwriters case."

[fol. 148] A clearer and more concise statement of the extent of the McCarran Act, and also its limitations, could hardly be found.

In *North Little Rock Transportation Co.* v. *Casualty Reciprocal Exchange* (1950), 181 F. 2d, 174, the Court said:

"The purpose of the McCarran Act was to permit the States to continue the regulation of the business of insurance, unhampered, to the extent provided by the Act, by Federal legislation relating to interstate commerce. See *Prudential Insurance Co.* v. *Benjamin,* supra, p. 429 of 328 U.S.

"In view of what was said by the Supreme Court about the effect of the McCarran Act in the *Prudential Insurance Co.* case and the case of *Robertson* v. *People of State of Calif.,* 328 U.S. 440, 449, 461, there is no need for discussing the validity or effectiveness of the McCarran Act. A ruling that it is invalid or ineffectual, we think, would be absurd."

The *Prudential Insurance Company* case is directly in point. There, the Prudential company challenged a statute of South Carolina which imposed on foreign insurance companies as a condition of doing business within the state, an annual tax of 3% of premiums on business done in the state without reference to transactions, whether interstate or

local. It should be noted that the case did not involve purely intrastate matters, which the majority claim is the limit of the McCarran Act's effectiveness. This state tax was clearly discriminatory, affected interstate commerce, and would ordinarily have been stricken down. However, it was [fol. 149] not, and the reason given was that a state tax or regulation discriminating against interstate commerce which would be invalid under the commerce clause, in the absence of action by Congress, may be validated by the affirmative action of Congress consenting thereto. The only difference between the Prudential case and the one at bar is that the former deals with state taxation and the latter with state regulation. The McCarran Act covers both.

The majority view of jurisdiction under the McCarran Act is entirely different. They say the McCarran Act "was designed to permit the states to regulate, *in the traditional manner*, the business of insurance." They obviously do not mean they are permitted to regulate it as they did prior to the *South Eastern Underwriters* Case, because their decision in this case asserts the paramount power of Federal laws over those of the states.

No law of Congress was necessary to give the states a right to carry on activities within their own borders, designed to regulate insurance. That is covered under the police power, guaranteed to the states by the Constitution. Just as Congress with reference to powers under the commerce clause, state legislatures may exercise these powers or not as they choose, subject only to their own and the Federal Constitution. The real problems arise when the exercise of these powers come in conflict with the commerce clause. There, the Federal power is paramount. Parker v. Brown, 317 U.S. 34. *Southern Railway Company* v. *Railroad Comm. of Indiana*, 236 U.S. 439. But, as was pointed out in the latter case, Congress could have circumscribed its regulation so as to occupy a limited field." This intention to occupy a limited field is the very essence of the McCarran Act.

[fol. 150] Just how far the majority would go in disregarding this intention is well illustrated in the case at bar. For example, suppose a state having the model code should decide that certain advertising disseminated therein did not violate the law. Nevertheless, the Federal Trade Commission asserting its paramount power to regulate the flow

of commerce into the state comes to an opposite conclusion. Or suppose the state officials held the advertising was illegal, while the Federal Trade Commission held to the contrary. The majority decision does not recognize state regulation; it destroys it.

The cases cited do not support the majority position. Of course, the Federal government, under the commerce clause, may regulate the flow of lottery devices into a state, regardless of state laws on the subject. The reason is that Congress has never enacted in the lottery field an equivalent of the McCarran Act. It requires a violent stretching of the imagination to find any support in the *Sylvanus* decision. There, the defendant was indicted under a statute prohibiting the use of the mails to defraud. The power of Congress in mail fraud matters does not depend on interstate commerce; it is based on the exclusive Constitutional right to control the mails. Prior to the South-Eastern Underwriters case, immediately after and prior to the McCarran Act, and under the McCarran Act, the result would have been the same. As the Court well expressed it, "This indictment does not have to do with the regulation of the insurance business in Illinois. Rather it has to do with the question of whether defendants have used the mails in pursuance of a scheme so to manipulate their authorized regulated business in Illinois as to result in fraudulent [fol. 151] deception of its prospective policy holders. The charge is not that the corporate charter should be ignored or that the administrative officers of Illinois may not perform their statutory duties and supervise and regulate the company's insurance business in Illinois, but goes to the use of the mails over which Congress has by the Constitution paramount power and authority."

The McCarran Act arrests the overriding power of the Federal government under the commerce clause as it affects insurance, where the states have regulatory laws. Nowhere does the Act express any intention of doing the same with the power to regulate the mails, the power to enforce due process, or the many other constitutional powers.

To us, the conclusion is inescapable that under the majority view, the McCarran Act accomplished nothing. Courts will not presume that a statute was meant to have no effect. On the contrary, it will be presumed that the

legislative body intended to make some change in existing laws, particularly where the whole history shows they intended to remedy what they thought was an existing evil. This rule is usually applied in situations where the overall intent is not clearly expressed in clear language.

Here, the majority would reverse these well-known rules of statutory construction in order to prove that Congress accomplished nothing. They, in effect, rewrite portions of the McCarran Act as follows:

That the Congress hereby declares that paramount regulation and taxation by the Federal government [fol. 152] of the business of insurance, rather than the continued regulation and taxation thereof by the several states, is in the public interest.

Section 2 (a). The business of insurance, and every person engaged therein shall be subject to the laws of the several states which relate to the regulation or taxation of such business, only to the extent that such laws do not conflict with the paramount Federal power under the commerce clause.

Section 2 (b). Any act of Congress, whether it specially relate to the business of insurance or not, shall be construed to invalidate, impair or suspend any law enacted by any state for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, whenever the state law conflicts with such act of Congress. The Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance regardless of any state regulation on the subject.

II

Our second objection to the majority opinion is that it would return the insurance business to the confusion into which it was plunged by the South-Eastern Underwriters decision. The nature and extent of that confusion was well expressed by the dissenting Judges. The late Mr. Chief Justice Stone said:

[fol. 153] " * * And in view of the broad powers of the federal government to regulate matters which, though not

themselves commerce, nevertheless affect interstate commerce, *Wickard* v. *Filburn*, 317 U.S. Ill.; *Polish Alliance* v. *Labor Board, supra*, there can be no doubt of the power of Congress if it so desires to regulate many aspects of the insurance business mentioned in this indictment.

"But the immediate and only practical effect of the decision now rendered is to withdraw from the states, in large measure, the regulation of insurance and to confer it on the national government, which has adopted no legislative policy and evolved no scheme of regulation with respect to the business of insurance. Congress having taken no action, the present decision substitutes, for the varied and detailed state regulation developed over a period of years, the limited aim and indefinite command of the Sherman Act for the suppression of restraints on competition in the marketing of goods and services in or affecting interstate commerce, to be applied by the Courts to the insurance business as best they may.

"In the years since this Court's pronouncement that insurance is not commerce came to be regarded as settled constitutional doctrine, vast efforts have gone into the development of schemes of state regulation and into the organization of the insurance business in conformity to such regulatory requirements. Vast amounts of capital have been invested in the business in reliance on the permanence of the existing system of state regulation. How far that system is now supplanted is not, and in the nature of things could not well be, explained in the court's opinion. The Government admits that statutes of at least five states [fol. 154] will be invalidated by the decision as in conflict with the Sherman Act, and the argument in this Court reveals serious doubt whether many others may not also be inconsistent with that Act. The extent to which still other state statutes will now be invalidated as in conflict with the commerce clause has not been explored in any detail in the briefs and argument or in the Court's opinion."

The late Mr. Justice Jackson said:

"The states began nearly a century ago to regulate insurance, and state regulation, while no doubt of uneven quality, today is a successful going concern. Several of

the states, where the greatest volume of business is transacted, have rigorous and enlightened legislation, with enforcement and supervision in the hands of experienced and competent officials. Such state departments, through trial and error, have accumulated that body of institutional experience and wisdom so indispensable to good administration. The Court's decision at very least will require an extensive overhauling of state legislation relating to taxation and supervision. The whole legal basis will have to be reconsidered. What will be irretrievably lost and what may be salvaged no one now can say, and it will take a generation of litigation to determine. Certainly the states lose very important controls and very considerable revenues.

"The recklessness of such a course is emphasized when we consider that Congress has not one line of legislation deliberately designed to take over federal responsibility for this important and complicated enterprise. * * *

"It is impossible to believe that Congress, if it ever intended to assume responsibility for general regulation [fol. 155] of insurance, would have made the antitrust laws the sole manifestation of its purpose. Its only command is to refrain from restraints of trade. Intelligent insurance regulation goes much further. It requires careful supervision to ascertain and protect solvency, regulation which may be inconsistent with unbridled rate competition. It prescribes some provisions of policies of insurance and many other matters beyond the scope of the Sherman Act.

"Also it requires sanctions for obedience far more effective than the $5,000 maximum fine on corporations prescribed by the antitrust laws. Violation of state laws are commonly punishable by cancellation of permission to do busines therein—a drastic sanction that really commands respect."

The accident and health insurance industry is a large and important one; yet, it is a small part of the business of insurance. This case, under Section 5 of the Federal Trade Commission Act, involves only a matter of advertising. But Section 5 is a comprehensive section which covers many things, such as combinations and restraints under the Sherman Act and at common law, price fixing, and many

other things which the Federal Trade Commission might hold to be unfair methods of competition.

As has been frequently said, insurance is a business effected with a public interest. Many years of regulation in 48 states have developed the fact that insurance has some problems peculiar to the business. One is the necessity of maintaining an industry whose financial ability to meet obligations accruing many years in the future will not be undermined by short term considerations. Consequently, the states have asserted their right to regulate the financial polices of the companies licensed to do business [fol. 156] in their states, to demand the deposit of certain reserves, to regulate and even limit competition, to fix rates, etc. Some of the regulations permit, or even require, cooperative action among insurance companies which could easily be contrary to the philosophy of the Federal anti-trust laws.

In this connection, the majority opinion says:

"However, as we have already said, our proceeding to abate deceptive practices by such companies does not impinge on those state functions, and we do not believe that the Federal Trade Commission Act can be properly interpreted to interfere with the taxing or rate-fixing powers."

We have already called attention to the breadth and extent of the Federal power to regulate the flow of commerce and also to the extensive power under the "affecting interstate commerce" theory to regulate matters entirely within the state which were once thought to be far removed from Federal authority. In South-Eastern Underwriters, the Supreme Court called attention to the many activities of a modern insurance company which involved or affected interstate commerce as we now know it. Such activities are necessarily centered in a home office. From there and to there, flows a constant stream of advertising brochures, policies, applications, statements, rate schedules, directions, etc. These have to do with all the activities of the insurance business and are not restricted to advertising.

In this case, jurisdiction is based on the admitted fact that the respondent sent bundles of advertising matter [fol. 157] into states where it was licensed to do busi-

ness. Actual dissemination of the advertising occurred entirely within the state. Except for the McCarran Act, it is clear this limited proof would sustain paramount Federal jurisdiction. Just how the majority arrive at the conclusion that similar proof would not sustain Federal jurisdiction in taxing and rate-making matters is not clear.

In fact, the decision in *North Little Rock Transportation Co.* v. *Casualty Reciprocal Exchange, supra,* is to the contrary. That case involved an appeal from a summary judgment of dismissal of a treble damage suit. The dismissal was based upon a determination that the fixing of rates by the National Bureau of Casualty Underwriters for casualty insurance written in the State of Arkansas by the members and subscribers of the Bureau is not violative of the Sherman Act, as amended. The Court adopted the findings of the District Court, one of which was:

"3. In the absence of public regulation or Congressional exemption, the price fixing activities of the Bureau involved in this case would constitute a violation of the Sherman Act." 85 F. Supp. 961, at p. 964.

The Circuit Court of Appeals affirmed the holding of the District Court that the McCarran Act permitted the State of Arkansas to continue the regulation of insurance in the matter of rate fixing, which regulation, without the McCarran Act, would have violated the Sherman Act.

It is our conclusion that the majority opinion would bring tremendous confusion in the insurance industry and would open the door wide to complete Federal control. We are not discussing the relative merits of Federal versus state control. All we say is that the decision belongs to [fol. 158] Congress and not to a Federal bureau.

The hearing examiner, after applying the jurisdictional tests to which we subscribe, concluded that in all states in which respondent was licensed to do business, except Mississippi, state regulation did exist. The hearing examiner then considered the alleged illegal advertising in Mississippi and concluded that it did not violate the Federal Trade Commission Act.

We have repeatedly pointed out that, under the McCarran Act, the Federal Trade Commission has some juris-

diction in the business of insurance. Within that jurisdiction, and in performance of duties imposed by Congress, 41 complaints have been issued. Where the Commission has jurisdiction, we would hold insurance companies to a high degree of responsibility in their dealings with the public. Consequently, we do not approve of some of the statements made by the hearing examiner in his consideration of the advertising in question.

However, that matter is not now before us. Since the filing of the initial decision, Mississippi has adopted the model code, effective as of February 29, 1956.

The law governing such a situation is clearly expressed in *United Corporation, et al.*, v. *Federal Trade Commission* (1940), 110 F. 2d 473, as follows:

"And since the power of the Federal Trade Commission is purely regulatory and not punitive, it is clear that jurisdiction must exist at the time of the entry of its order. Jurisdiction at the time of the commission of acts objected to as unfair trade practices or at the time of the [fol. 159] filing of the complaint with regard thereto is not sufficient; for the order to be entered does not relate to past practices or determine rights as of the time of the filing of the complaint, as in an action at law, but commands or forbids action in the future."

In *Chamber of Commerce of Minneapolis, et al.* v. *Federal Trade Commission* (1926), 13 F. 2d 673, the Court said:

"As the orders of the Commission are purely remedial and preventative, the effect thereof is entirely in the future. Therefore, the jurisdiction of the Commission should, in this respect, be measured as of the time of the order rather than as of the filing of the complaint or as of the hearing thereon."

It thus appears that in every state involved in this case, state regulation now prevents further action by the Commission.

In accordance with the views expressed in this dissent, we would deny the appeal and dismiss the complaint.

April 24, 1956.

[fol. 160] ADDITIONAL VIEWS OF COMMISSIONER MASON—April 24, 1956

The issue here resolves itself basically into that ever fundamental question—states' rights versus centralized government.

Our problem is not the determination of which philosophy is right—that is a legislative function. Our sole duty is to determine which road Congress has directed us to follow in the instant matter.

In my opinion, if the rationale on which the majority bases its decision in this case stands, it must of necessity follow that the Federal Government has almost unlimited control over the management of the insurance business.

This would apply not only to false advertising of health and accident policies, the present center of our attention in 41 cases, but would include all other aspects of the business of insurance, such as the approval of policy forms, the establishment of rates, the maintenance of reserves, the regulation of agency commissions, and the countless other components of the internal management of any single company or companies.

[fol. 161] To transfer in one fell swoop the control of every phase of the business of insurance, whether regulated or not by state law, to the Federal Government when crossing state lines is to flout the expressed intent of Congress.

April 24, 1956.

BEFORE FEDERAL TRADE COMMISSION

MINUTE ENTRIES

Answer of Counsel supporting Complaint to Respondent's Motion to include Mississippi Law in Record and to Dismiss Complaint;

Order of Secretary of Federal Trade Commission on Ruling on Motion of Respondent, issued 5/11/56;

Omitted from the Printed Record, pursuant to Petitioner's Designation as to Printing record, copied at page 1.

* * * * * * *

Before Federal Trade Commission

Secretary's Certificate to Record

I, Robert M. Parrish, Secretary of the Federal Trade Commission and official custodian of its records, do hereby [fol. 162] certify that transmitted herewith is a full, true, and complete transcript of proceedings had before the Federal Trade Commission in the above entitled matter, in four parts, as follows:

Part 1—Pleadings.

Part 2—Testimony.

Argument.

Part 3—Exhibits—Documentary—Commission 1 to 46, incl.

Part 4—Exhibits—Documentary—Commission 47 to 58, incl.

That his transcript is certified to the United States Court of Appeals for the Fifth Circuit, pursuant to the filing in said Court of an Order to Cease and Desist, issued by the Federal Trade Commission April 24, 1956, in the above indicated proceeding.

In witness whereof, I hereunto subscribe my name, and affix the seal of the said Federal Trade Commission, at its office in the City of Washington, D. C., this 5th day of July, A. D. 1956.

Robert M. Parrish, Secretary. (Seal.)

Testimony filed in Part 2 Exhibits to testimony filed in Parts 3 and 4.

[fol. 163] IN UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 16132

THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY,

versus

FEDERAL TRADE COMMISSION

ARGUMENT AND SUBMISSION—Jan. 29, 1957

On this day this cause was called, and after argument by J. D. Wheeler, Esq., for petitioner and Robert B. Dawkins, Esq., Assistant General Counsel, Federal Trade Commission, for respondent, was submitted to the Court.

[fol. 164] IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 16132

THE AMERICAN HOSPITAL AND LIFE INSURANCE COMPANY—Petitioner,

versus

FEDERAL TRADE COMMISSION, Respondent

Petition for Review of an Order of the Federal Trade Commission, sitting at Washington, D. C.

OPINION—April 9, 1957

Before Hutcheson, Chief Judge, and Cameron and Jones, Circuit Judges.

JONES, Circuit Judge: The petitioner, the American Hospital and Life Insurance Company, is a corporation of Texas. Its principal or home office is in San Antonio, Texas. It is engaged in the business of writing health and accident insurance. It has been licensed to do business and is doing

business in Arizona, Arkansas, Colorado, Illinois, Indiana, [fol. 165] Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma and Tennessee, as well as in the State of Texas. In each of these states the petitioner has agents through whom its business is conducted. Each of the states has statutes forbidding deceptive and misleading advertising. The petitioner employed printed brochures which it sent from its home office to its agents for use in advertising and soliciting business. It did no advertising by newspapers or other periodicals or by radio or television. The Federal Trade Commission issued its complaint against the petitioner charging it with engaging in unfair and deceptive advertising practices in commerce in violation of the Federal Trade Commission Act, 15 U.S.C.A. §41, et seq. The petitioner asserted that its advertising was not false, misleading or deceptive. It also contended that the Commission was without jurisdiction because of the McCarran Act. After hearing the Examiner of the Commission, in an initial decision, held that the charges concerning the petitioner's advertising had not been sustained. The Examiner also held that the Commission was without jurisdiction, except as to petitioner's transactions in Mississippi where, at the time of the hearing, there was no adequate law regulating false and deceptive acts and practices. The Commission, on appeal, set aside the initial decision of the Examiner by a three to two decision. It determined that in passing the McCarran Act the Congress did not, and did not intend to, deprive the Commission of the power to regulate and control the interstate activities of insurance companies. It found the advertising brochures which had been sent from Texas to the other states were false and deceptive. It [fol. 166] entered a Cease and Desist Order which is before us for review. In the opinion of the majority of the Commission, it was said that "there must remain an irreducible area of Commission jurisdiction over the interstate activities of insurance companies which cannot be reached by state law."

In the South-Eastern Underwriters case,[1] of which more will be hereafter said, Mr. Justice Black, in the majority opinion observed that "Perhaps no modern commercial

[1] United States v. South-Eastern Underwriters Association, 322 U. S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440.

enterprise directly affects so many people as does the insurance business". Although it has not been classed as a public utility charged with the duty of serving all who may apply,[2] the business of insurance has been more generally regulated than any other sphere of business activities not a public utility.[3] It was determined in 1868 that the insurance business did not constitute transactions in commerce,[4] and this doctrine was adhered to in many subsequent decisons.[5] In 1944 came the South-Eastern case, *supra*, where, in a four to three decision, with two justices of the court not participating, it was held generally that insurance businesses are engaged in "commerce among the several states", and specifically that the Sherman Anti-Trust Act[6] applied to insurance activities. Mr. [fol. 167]. Chief Justice Stone, in his dissenting opinion, said that the action of the majority in overturning the precedents of the seventy-five years "cannot fail to be the occasion for loosing a flood of litigation and of legislation, state and national, in order to establish a new boundary between state and national power raising questions which cannot be answ-ed for years to come * * * ".[7] The litigation has not yet reached the flood stage and the McCarran-Ferguson Act,[8] sometimes referred to as Public Law 15, and more often merely as the McCarran Act, has been the only national legislation of consequence resulting from

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[2] National Union Fire Insurance Co. v. Dickinson, 128 Ark. 367, 194 S. W. 254.

[3] For a statement of the reasons for and history of the regulation of insurance see 1 Richards on Insurance, 5th Ed. 136, et seq.

[4] Paul v. Virginia, 8 Wall. (U.S. 168, 19 L.Ed. 357.

[5] These were reviewed by the Supreme Court in 1913, where it was said of the prior decisions "they constitute a formidable body of authority and strongly invoke the sanction of the rule of stare decisis." New York Life Insurance Co. v. Deer Lodge County, 231 U.S. 495, 34 S. Ct. 167, 58 L. Ed. 332.

[6] 15 U.S.C.A. § 1 et seq.

[7] 322 U. S. 583.

[8] 59 Stat. 33, 15 U.S.C.A. §§ 1011-1015.

tne decision. This act was proposed by Senators McCarran and Ferguson and on March 9, 1945, it was signed by the President and became a law. The enactment is brief and many of its provisions are here pertinent.[9]

[fol. 168] The purpose and effect of the McCarran Act has been stated by the Supreme Court, it saying:

> "Obviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance. This was done in two ways. One was by removing obstructions which might be thought to flow from its own power, whether dormant or exercised, except as otherwise expressly provided in the Act itself or in future legislation. The other was by declaring expressly and affirmatively that continued state regulation and taxation of this business is in the public interest and that

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[9] An act to express the intent of the Congress with reference to the regulation of the business of insurance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled, That: The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Sec. 2. (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1941, as amended, known as the Clayton Act, and the act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the

the business and all who engage in it 'shall be subject to' the laws of the several states in these respects.

"Moreover, in taking this action Congress must have had full knowledge of the nation-wide existence of state systems of regulation and taxation; of the fact that [fol. 169] they differ greatly in the scope and character of the regulations imposed and of the taxes exacted; and of the further fact that many, if not all, include features which, to some extent, have not been applied generally to other interstate business. Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these varia-

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business of insurance to the extent that such business is not regulated by State law.

Sec. 3. (a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Sec. 4. Nothing contained in this Act shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

Sec. 5. As used in this Act, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

Sec. 6. If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.

tions." *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 66 S. Ct. 1142, 90 L. Ed. 1342. See *North Little Rock Transp. Co.* v. *Casualty Reciprocal Exchange*, 8th Cir. 1950, 181 F. 2d 174; *American Universal Ins. Co.* v. *Sterling*, 3rd Cir. 1952, 203 F. 2d 159.

By the Act it was provided not only that the business of insurance should be subjected to regulation by the States, but that until June 30, 1948,[10] the Sherman Act, the Clayton Act and the Robinson-Patman Act should not apply to the business of insurance, and after that date the Sherman and Clayton Acts and the Federal Trade Commission Act should apply to such business to the the extent it is not regulated by State law. It is also provided that nothing contained in the Act shall render the Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation. Then too it was provided that the Act should not affect the application of the National Labor Relations Act, the Fair Labor Standards Act or the Merchant Marine Act to the business of insurance. These provisions evidence a design on the part of Congress to yield to the States which had undertaken, or which would [fol. 170] undertake, to regulate the insurance business in those fields in which the Sherman Act might otherwise have been applicable, with the exception of boycotts, coercion and intimidation. Such was the intent of the Congress. Senator McCarran, in response to the query of a colleague, said:

> "The Senator will recall the Southeastern Underwriters case. The decision was startling. It created consternation in the insurance business because by previous decisions rendered during the past 50 years or more we were entitled to believe that the business of insurance was not to be classified as interstate commerce. The Supreme Court of the United States specifically, directly, and emphatically put it into the category of interstate commerce. It put it squarely

[10] The moratorium, intended to permit the States to enact regulatory measures if the laws were inadequate for the purpose, was extended from January 1, 1948, to June 30, 1948, by Act July 25, 1947, c. 326, 61 Stat. 448.

> under the Sherman Act, the Clayton Act, and other Acts. The pending bill is for the purpose of creating a moratorium for 3 years in order that the business of insurance shall not be interfered with by any Federal power under either the Clayton Act or the Sherman Act. So during the period of moratorium the various states themselves may take steps to regulate the business of insurance."

Senator McCarran again said: "The moratorium would not be continued; but if in the meantime the states themselves had regulated the business of insurance, the Sherman and Clayton Acts and the other Acts would not be effective."

The Commission urges that a state does not have and never did have the power adequately to control the advertising practices of out-of-state insurance companies doing [fol. 171] business within its boundaries. The Congress, seemingly, had no doubt that a state might exercise such power and we have none. The Supreme Court, we think, has expressed the same view in holding, with respect to another phase of state insurance regulation.

> "These regulations can not be attacked merely because they affect business activities which are carried on outside the state. Of necessity, any regulations affecting the solvency of those doing an insurance business in a state must have some effect on business practices of the same company outside the state. Nothing in the Constitution requires a state to nullify its own protective standards because an enterprise regulated has its headquarters elsewhere. The power New York may exercise to regulate domestic insurance associations may be applied to foreign associations which New York permits to conduct the same kind of business." *Hoopeston Canning Co.* v. *Cullen*, 318 U. S. 313, 63 S. Ct. 602, 87 L. Ed. 777.

If there is an "irreducible area" of Commission jurisdiction, we are of the firm conviction that the matter presented by the record before us is not within it.

The Commission relied heavily upon *United States* v. *Sultanus*[11] in support of its jurisdiction. An indictment

[11] 7th Cir. 1951, 192 F. 2d 96.

was returned, in the Sylvanus case, for use of the mails to defraud in the sale of insurance by mail. The McCarran Act was held to be no bar to prosecution. A fraudulent scheme carried on by use of the mails would violate the mail fraud acts even though the mails never crossed a state [fol. 172] boundary.[12] The doctrine of the case, with the decision of which we have no disagreement, is of no bearing on the problem before us here. A violation of the postal laws does not of itself confer jurisdiction on the Federal Trade Commission.

The Commission's Examiner found that each of the States in which the petitioner did business, except Mississippi, had enacted laws for the regulation of false and deceptive advertising. Mississippi enacted such a law while the matter was pending before the Commission. This is not controverted. The Examiner found that the petitioner's advertising matter was not false, misleading or deceptive. Holding, as we do, that the Commission was without jurisdiction, we do not reach the merits.

The order of the Commission is set aside and

Reversed.

[fol. 173] In United States Court of Appeals

No. 16132

The American Hospital and Life Insurance Company

versus

Federal Trade Commission

Judgment—April 9, 1957

This cause came on to be heard on the petition of The American Hospital and Life Insurance Company for review of an Order of the Federal Trade Commission issued on April 24, 1956, in Docket No. 6237, and was argued by counsel:

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[12] See New York Life Insurance Co. v. Deer Lodge County, supra.

On consideration whereof, It is now here ordered, adjudged and decreed by this Court that the order of the Commission in this cause be, and the same is hereby, set aside and reversed.

[fol. 174] Clerk's Certificate to foregoing transcript omitted in printing.

[fol. 175] Supreme Court of the United States, October Term, 1956

No. 436

Federal Trade Commission, Petitioner,

vs.

The American Hospital and Life Insurance Company

Order Extending Time to File Petition for Writ of Certiorari—June 27, 1957

Upon Consideration of the application of counsel for petitioner,

It Is Ordered that the time for filing petition for writ of certiorari in the above-entitled cause be, and the same is hereby, extended to and including September 6th, 1957.

(S.) Hugo L. Black, Associate Justice of the Supreme Court of the United States.

Dated this 27th day of June 1957.

[fol. 176] SUPREME COURT OF THE UNITED STATES

[Title omitted]

ORDER ALLOWING CERTIORARI—November 12, 1957

The petition herein for a writ of certiorari to the United States Circuit Court of Appeals for the Fifth Circuit is granted. The case is consolidated with No. 435 and a total of two hours allowed for oral argument.

And it is further ordered that the duly certified copy of the transcript of the proceedings below which accompanied the petition shall be treated as though filed in response to such writ.